Michigan Conference of Teamsters Welfare Fund

Messenger

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Message from MCTWF's Executive Director

Dear Teamster Families,

We're two very busy months into our new relationship with Blue Cross Blue Shield of Michigan and the nationwide Blue Cross Blue Shield PPO Network. Despite more than a half year of intensive planning, designing and testing, supported by the brightest and most experienced BCBSM and MCTWF staff, I admit to having had trepidations about moving forward in January with this transition. However, with having implemented a 100% review of all claims prior to final adjudication at both BCBSM and MCTWF, with dedicated teams to attack any issues that arise and with having tested as thoroughly as was reasonable, we proceeded. I'm gratified to report that all of the effort that has been poured into this project, and which continues to this day, has resulted in an amazingly successful outcome. Yes, unfortunately, there have been inevitable, unforeseen problems, but BCBSM advises me that this has been the smoothest, most trouble free project of its size, with which it has been involved. In no way do we excuse or minimize the impact of any transitional problems that may have affected you, but clearly, they have been relatively few, well contained and fixed quickly.

Your indulgence will pay off. You now have access to a far larger network of providers, available almost anywhere you reside or travel, with programs to incentivize the delivery of quality health care through adoption of best medical practices and subject to enlightened medical policies. You now have less out-of-pocket expense exposure to deductibles, coinsurance charges and balance bills. You will be benefited by the consolidation of your medical claims with your prescription drug claims at BCBSM, which will facilitate BlueHealthConnection's efforts at identifying and supporting you with chronic disease and high risk condition management programs. And, you will continue to have the security of MCTWF's processing, or immediate review, of every claim, its communication of every explanation of benefit, its response to every patient inquiry and its handling of every participant appeal. We will be soliciting your feedback through surveys to be conducted later this year.

This issue of the *Messenger* addresses a number of matters that require your attention. Please note the change in the manner in which chiropractic services received on or after April 1, 2006 will be determined as being covered, the correction to Key Plan Schedules of Benefits regarding hearing aids, the clarification of death benefit eligibility, the expansion of medical coverage for dental services to include those necessitated by congenital abnormalities, the expansion of medical benefits to cover optometrist services, the limitation of coverage for prosthetics and orthotics to certified or accredited suppliers and the expansion of MCTWF's strike coverage rules to include lockouts. This issue also notifies you of the Trustees' decision to renew benefit bank weeks for the next three years. However, please note that allotted weeks have been reduced by one fourth and that non-medical/non-prescription drug bank week benefits have been eliminated. Also, please take note of the April 2006 Retiree Medical Program self-contribution rates, which are up approximately 6% from this past year's rates and new rules regarding reimbursement of your direct payments to pharmacies for prescription drugs.

On behalf of the Trustees and staff, I send best wishes for a great Spring season.

Richard Burker

Inside this issue:

REMINDER: MCTWF is required by law to maintain the confidentiality of your individually identifiable health information. A detailed description of how your medical information may be used, as well as your right to access your medical information, can be found in the Fall 2002 issue of the *Messenger*. You also may request a copy from MCTWF's Customer Service Department at the numbers listed on the back of this newsletter.

Retiree Medical Program Rates
Effective April 1, 2006

Effective April 1, 2006, the below self contribution rates will apply to all those participating in MCTWF's Retiree Medical Program:

Retiree Medical Program Rates *Effective April 1, 2006 through March 31, 2007*						
Monthly Self-Contribution Rate Covering Both Retiree and Spouse						
Age at Retirement	Years in Fund 5 - 9	Years in Fund 10 - 14	Years in Fund 15 - 19	Years in Fund 20 - 24	Years in Fund 25 - 29	Years in Fund 30 +
50 - 54	$465.00	$425.00	$380.00	$340.00	$295.00	$255.00
55 - 59	$360.00	$335.00	$305.00	$285.00	$260.00	$235.00
60 - 64	$255.00	$245.00	$240.00	$230.00	$220.00	$210.00
For participants who retired before January 1, 2002 $210.00						

Participants contemplating retirement should refer to MCTWF's age and service rules for Program eligibility.

Lockout Coverage Rule

Effective October 1, 2005, the Trustees have expanded MCTWF's *Extended Coverage Rule for Sanctioned Strikes* to include lockouts as follows:

The following conditions must be met in order for MCTWF to provide Extended Coverage to participants who are absent from employment due to a strike or lockout –

- The strike must be sanctioned by the IBT or the locked out employees must be supported by the IBT, as evidenced by IBT strike wages, and
- The Teamsters Local Union involved must provide MCTWF with confirmation of said IBT sanctioning or support, the inception and termination dates, and a list of affected participants, and
- The Employer involved must not be more than 30 days delinquent in making legally required contributions to MCTWF at the commencement of the sanctioned strike or lockout.

The following limitations will apply when extended coverage is granted –

- Extended coverage will not be provided to participants whose employment status as of the date the sanctioned strike or lockout begins is one of the following – leave of absence or sick leave (until return from leave), laid off, or terminated.
- Upon exhaustion of available benefit bank weeks, extended coverage shall continue for a maximum of eight weeks.
- The COBRA coverage continuation period will be offset by the number of benefit bank weeks used following the commencement of the sanctioned strike or lockout and the number of weeks of extended coverage.

COBRA notices will be sent to participants prior to the cessation of extended coverage. The COBRA period runs from the "qualifying event" (i.e., the strike or lockout) and is reduced by the number of remaining benefit bank weeks plus the eight weeks of extended coverage provided by MCTWF.

Chiropractic Services

Prior to MCTWF's transition to the Blue Cross Blue Shield PPO Network, chiropractic services were deemed by it to be eligible for coverage based solely on the nature of services rendered. Effective April 1, 2006, MCTWF will conform with BCBSM's medical policy, which requires a diagnosis that BCBSM recognizes as treatable with chiropractic services. A review of MCTWF chiropractic claims over the past 12 months reveals only a small number of participants receiving chiropractic services without an appropriate diagnosis code. MCTWF will correspond directly with affected participants.

Benefit Bank Renewal

We are pleased to announce that, despite the relentless crush of double digit benefit expense inflation, the Trustees have resolved to renew MCTWF's benefit bank week provision for the 36 month period beginning April 1, 2006 for Medical Plans SOA, TIF, Key I and Key II. However, the following changes have been made from the April 2003 renewal:

- Effective April 1, 2006, eligible employees (participants) who are actively employed as of that date, and on whose behalf company contributions are being made, will be allotted **six** (reduced from eight) benefit bank weeks for use during the period April 1, 2006 through March 31, 2009.
- Effective April 1, 2006, **bank week benefits will be limited to the related plan's medical and prescription drug benefits.** Accordingly, no optical, dental, total and permanent disability, or death benefits will be available when incurred during benefit bank weeks. Also, as is currently the case, no short term disability ("loss of time") benefits will be available when incurred during benefit bank weeks.

The following policies remain unchanged (except as stated above):

- Participants who are not actively employed and who are in the process of using their current benefit bank week allotment on the March 31, 2006 expiration date may continue to use these weeks until the earlier of their return to employment or the exhaustion of their bank weeks. Upon their return to active employment, these participants will be allotted a renewal of six benefit bank weeks through March 31, 2009.
- Participants who are not actively employed and who have exhausted their current benefit bank week allotment by the March 31, 2006 expiration date, upon their return to active employment or if later, upon their re-establishment of eligibility for active benefits, will receive a six benefit bank week renewal through March 31, 2009.

Correction to the Key I & Key II Schedules of Benefits

The Key I and Key II Package Plan and Cafeteria Plan (Key Plans) Schedules of Benefits unintentionally fail to state that in-network and out-of-network Hearing Aid benefits are subject to Plan deductibles.

Key I Package and Cafeteria Plans Schedules of Benefits are revised as follows:

Benefit	In-Network	Out-of-Network
Hearing Aids covered every 2 years	90% of CC **after deductible** up to $1,000 per aid ($2,000 maximum benefit)	80% of MAB **after deductible** up to $1,000 per aid ($2,000 maximum benefit)

Key II Package and Cafeteria Plans Schedules of Benefits are revised as follows:

Benefit	In-Network	Out-of-Network
Hearing Aids covered every 2 years	85% of CC **after deductible** up to $1,000 per aid ($2,000 maximum benefit)	75% of MAB **after deductible** up to $1,000 per aid ($2,000 maximum benefit)

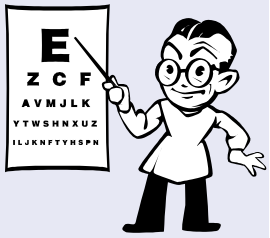
Note: CC refers to contracted (allowed) charges. MAB refers to maximum allowable benefits.

All Key Plan Schedules of Benefits are available on the MCTWF website at www.mctwf.org (please go to the *Summary Plan Description* page and click on "Schedule of Benefits").

Coverage for Prosthetic and Orthotic Devices

Effective April 1, 2006, MCTWF will deny coverage for prosthetic and orthotic devices that are not obtained from suppliers that maintain certification or accreditation from the American Board of Certification. In order to obtain a prosthetic or orthotic device, your treating physician will provide you with a prescription that must be filled by an authorized supplier. Prior authorization is not necessary for prosthetic and orthotic devices; however, the device must meet MCTWF's medical necessity criteria. Please contact MCTWF's Customer Service Department for a referral to the nearest authorized participating BCBS provider.

Coverage for Optometrist Services



Effective April 1, 2006, MCTWF will reimburse optometrists for services within their licensed scope of treatment that meet MCTWF's medical necessity criteria. Previously, MCTWF reimbursed optometrists only for those services covered as an optical benefit. The diagnoses and services billed will determine whether eligible claims will be reimbursed as a medical or optical benefit.

Prescription Drug Reimbursement Rules

Under certain circumstances, eligible participants may find it necessary to pay a pharmacy directly for the full cost of their prescription drugs. The following table reflects the circumstances under which MCTWF will reimburse incurred expenses for prescription drugs and the level of such reimbursement:

Circumstance	MCTWF Level of Reimbursement
Eligibility established retroactively after prescription filled through no fault of the participant (e.g., paperwork is not received timely from a newly contributing employer).	Reimburse 100% of charges, less the applicable co-payment.
Prescription filled prior to establishing COBRA coverage.	Reimburse the amount determined by BCBSM to be appropriate, less the applicable co-payment.
Prescription filled that is rejected by BCBSM, but is subsequently approved pursuant to MCTWF's Medical Director review.	Reimburse the amount determined by BCBSM to be appropriate, less the applicable co-payment.
Compound prescription filled that is rejected by BCBSM and subsequently approved pursuant to BCBSM review.	Reimburse the amount determined by BCBSM to be appropriate, less the applicable co-payment.
Prescription filled at a non-participating (out-of-network) pharmacy.	Reimburse the amount determined by BCBSM to be appropriate, less the applicable co-payment.

When submitting a request for reimbursement of prescription drug expenses charged by a participating (network) pharmacy, you must provide an itemized receipt and include the participant's Contract Number. For reimbursement of non-participating pharmacy charges, you must submit, in addition to the itemized receipt, a copy of the written prescription from the prescribing physician.

Medical Coverage for Dental Services

Currently, subject to Plan structure and limits, all MCTWF Plans that provide medical benefits include coverage for dental services received for repair of accidental injury (other than work-related or non-covered auto-related) to natural teeth. Effective October 27, 2005, the Trustees expanded that coverage to include the correction of congenital and genetic dental abnormalities. The Trustees also clarified that in either the case of accidental injury, congenital or genetic abnormality, allowed charges first will be applied against the available dental limits in your MCTWF Plan before being applied against your medical limits.

For example, an SOA participant is accidentally hit in the mouth playing hockey or his dependent child is born with a condition which does not produce permanent teeth. In either case, Class III restorative dental work is performed totaling $10,000 in allowed charges. Assuming that the participant or child has his full $2,000 of annual dental benefits remaining and because Class III benefits are covered at 85%, MCTWF would pay $2,000, the patient would pay $353. The remaining $7,547 would be applied to medical benefits, under the Extended Benefits category (formerly, Major Medical), subject to a $100 annual deductible and MCTWF coverage at 80% of the remaining allowed charges.

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 and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women's Health Act, group plans offering mastectomy coverage 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 lymph edemas.

MCTWF provided this coverage for many years prior to the enactment of this law and continues to do so.

Childhood and Adolescent Immunization Schedule 2006

Every year the Centers for Disease Control's Advisory Committee on Immunization Practices, the American Academy of Family Physicians and the American Academy of Pediatrics reviews, and if necessary, revises the recommended childhood and adolescent immunization schedule. Below is the 2006 Childhood and Adolescent Immunization Schedule which lists each vaccine under the routinely recommended ages. We believe that you will find this schedule particularly valuable for your children beyond 18 months of age who are no longer frequently seeing their pediatrician.

Range of recommended ages | **Catch-up immunization** | **11-12 year old assessment**

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs.	13-14 yrs	15 yrs	16-18 yrs
Hepatitis B	HepB	HepB		HepB	HepB				Hep B Series					
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DtaP		DTaP			DTaP	Tdap	Tdap		
Haemophilus Influenzae Type b			Hib	Hib	Hib	Hib								
Inactivated Poliovirus			IPV	IPV	IPV					IPV				
Measles, Mumps, Rubella						MMR				MMR	MMR			
Varicella						Varicella			Varicella					
Meningococcal											MCV4		MCV4	
									MPSV4			MCV4		
Pneumococcal			PCV	PCV	PCV	PCV			PPV	PPV				
Influenza					Influenza (annually)									
Hepatitis A						HepA Series								

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. [Vaccinations at non-color coded ages are permissible, but not recommended. The following notes to the chart are excerpted from the Department of Health and Human Services Centers for Disease Control and Prevention website, and can be accessed, in their entirety, at http://www.cdc.gov/nip/recs/child-schedule-color-print.pdf.]

1. Hepatitis B vaccine (HepB). *AT BIRTH:* All newborns should receive monovalent HepB soon after birth and before hospital discharge. Infants born to mothers who are HBsAg-positive should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth**.** Infants born to mothers whose HBsAg status is unknown should receive HepB within 12 hours of birth. *FOLLOWING THE BIRTHDOSE:* The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap – adolescent preparation) is recommended at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13–18 years who missed the 11–12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent tetanus and diphtheria toxoids (Td) are recommended every 10 years.

3. *Haemophilus influenzae* type b conjugate vaccine (Hib). Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

6. Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated.

7. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months.

8. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54[RR-8]:1-55). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. Hepatitis A vaccine (HepA). HepA is recommended for all children at 1 year of age (i.e.,12–23 months). The 2 doses in the series should be administered at least 6 months apart.

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

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The *Messenger*, published quarterly, 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

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DETROIT, MICHIGAN 48216
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Metro Detroit 1-800-572-7687
Upstate 1-800-824-3158
Out-of-State 1-800-334-9738

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Change of Beneficiary

Although the initial designation of the beneficiary of your death benefits, or of your residual total and permanent disability benefits, is made on your MCTWF *Enrollment Form*, changes should be made by completion of MCTWF's *Change of Beneficiary Form*. You may obtain this form by contacting MCTWF's Customer Service Department or by printing it from the *Forms* page of MCTWF's website at www.mctwf.org.

Death Benefit Eligibility Clarification

All MCTWF Plans that provide death benefits state in their Summary Plan Descriptions that:

"If you die from natural or accidental causes while you are eligible for benefits, your beneficiary is entitled to a benefit in the amount shown in your Schedule of Benefits."

The Trustees have sought to clarify entitlement by adopting the following replacement language:

If you die from natural or accidental causes while you are an eligible Employee, as defined in this SPD [Employee means a person who is working for a contributing employer under the terms of a collective bargaining agreement or whose employer makes contributions to the Fund under a participation agreement], **your beneficiary is entitled to a benefit in the amount shown in your Schedule of Benefits. Your beneficiary is not entitled to a death benefit if you die while you are receiving Total and Permanent Disability benefits, continuation coverage under COBRA, or Extended Disability Medical benefits.**

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