Michigan Conference of Teamsters Welfare Fund

Messenger

Volume 27, Issue 1

Winter 2008-2009

Message from MCTWF's Executive Director

Dear Teamster families;

After decades beyond memory, we appear to have a consensus among the key stakeholders that America's health care system is in need of fundamental reform; that the future economic well being of our nation is largely dependent upon it. The political will is mounting, lessons have been learned, the tracks will be laid either around, over, or through the obstacles, and once the train gets rolling, no would-be saboteur will be able to derail it. And so, it is no longer a pipe dream that all people within our borders, despite their economic circumstances, one day will have access to health care on a preventive basis, long before the need becomes acute; that public health policy will provoke the beginnings of a cultural shift in self perception so that eventually, we will tend to our own health as naturally and uncompromisingly as we do to the welfare of our families. The system will be forced into transparency; fraud, incompetence, and waste will be weeded out; health care providers will be held to high professional standards, judged on their outcomes, and exposed for their technical and ethical lapses; we will cease being a haven for profiteering drug manufacturers and their corrupted regulators. In reforming our health care system, the public's welfare must always be the essential focus. Access to quality health care must be acknowledged as a basic right of all Americans. Every component of the system must be driven by the public's insistence on excellence. Health care providers must be imbued with the profession's original mission; to serve the people. "In every house where I come I will enter only for the good of my patients...."

Turning our attention from Hippocrates to heartburn, the scientific literature suggests that we are much the cause of our own suffering from heartburn and related distress and that in many cases we can end the distress with life style changes and short term use of over-the-counter proton pump inhibitor (PPI) medication. Please refer to the article on page 6 of this issue of the *Messenger* for further discussion and rule changes, effective April 1, 2009.

The Federal Stimulus Program (American Recovery and Reinvestment Act), in a significant and remarkable move toward ensuring the affordability of health care for current laid off workers and their families, provides for federal subsidization of 65% of the cost of COBRA premiums for up to nine months prospectively for those whose employment was involuntarily terminated between September 1, 2008 and December 31, 2009. Please refer to the article on page 2. All participants with COBRA events since September 1, 2008 will receive a special notice from MCTWF advising them of their rights under the new law.

In light of the increased number of declared retirements and applications to enroll in MCTWF's Retiree Medical Program, we have devoted substantial space in this issue of the *Messenger* to reiterate Program eligibility rules. The rules are time sensitive and strictly enforced and so we urge you to familiarize yourselves with them to preserve your eligibility when you are planning to retire or when you have been laid off and meet the age and service requirements, and are uncertain as to whether you will be reemployed in eligible covered employment within 90 days. Also published in this issue are the Program self-contribution rates commencing April 1, 2009.

Also, please take note of the other important information in this *Messenger*, including the renewal of the six week benefit bank allotment for the next three years.

Special welcome to groups newly participating in MCTWF, including Teamsters Local 89 members in Shelbyville, KY and Local 614 members in Sterling Heights, MI both employed by RCS Transportation and Local 337 members employed in Detroit by the movie production companies Innocence Productions and DW Studios. Please be sure to speak to one of our Customer Communications representatives about any questions you have relating to your participation.

On behalf of our staff and Trustees, I wish you good health and a great Spring.

Richard Burker

Inside this issue:

Notice of Privacy Practices 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* or from the *HIPAA Privacy Rule* page of the MCTWF website. You also may request a copy from MCTWF's Customer Communications Department. Please refer to the phone numbers listed on the back of this newsletter.

COBRA Contribution Subsidization - American Recovery and Reinvestment Act

The American Recovery and Reinvestment Act (ARRA), enacted February 17, 2009, provides financial assistance to certain individuals ("Assistance Eligible Individuals" or AEIs) by subsidizing 65% of their COBRA continuation coverage contributions for up to nine months. New notices for COBRA qualified beneficiaries are being drafted by the responsible federal agencies and will be issued thereafter by MCTWF. The following is a summary of some key provisions of the statute:

Who are "Assistance Eligible Individuals" (AEIs) and when does their COBRA contribution rate subsidy commence ?

- COBRA qualified employees (e.g., MCTWF participants) involuntarily terminated (for reasons other than gross misconduct) between September 1, 2008 and December 31, 2009 and their COBRA qualified dependents are eligible for assistance under ARRA, subject to a phase out beginning with modified adjusted gross income limits of $125,000 for individuals filing singly ($250,000 if filing jointly).
- AEIs who either became eligible for COBRA coverage but had not elected COBRA by the February 17, 2009 enactment date, or had elected COBRA coverage but then dropped it for reasons other than due to eligibility under another group health plan or Medicare, will be given a second chance to elect coverage, subsidized at 65% (i.e., resulting in a COBRA contribution rate of 35% of normal cost), retroactive to the week of February 22, 2009 for up to nine months (although the maximum COBRA coverage period entitlement still runs from the original COBRA qualifying event; i.e., the employment termination). This second chance election must occur within 60 days of the issuance of a special notice, currently being drafted by the Department of Labor (which must be issued by the group health plan by April 18, 2009).
- AEIs who had elected COBRA coverage by February 17, 2009 will be entitled to the 65% rate subsidy retroactive to the week of February 22, 2009 for up to nine months.
- AEIs who elect COBRA coverage relative to an involuntary termination occurring on or after February 17, 2009 will be entitled to the 65% subsidy commencing with the first week following the termination, for up to nine months.
- ARRA provides a grace period for COBRA administrators to modify their billing systems. The full COBRA contribution rate may be charged for the period through April 2009 and the 65% subsidy will be credited against future COBRA contributions or will be refunded if the credit is not reasonably expected to be used within 180 days.
- Any individual claiming treatment as an AEI and who is denied such treatment by the group health plan may appeal to the Department of Labor or the Department of Health and Human Services, which must rule on the appeal within 15 business days.

When does the COBRA rate subsidy period end ?

The subsidy period ends after a maximum of nine months of contributions, but will cease earlier upon the termination of the maximum period of COBRA coverage, or upon becoming eligible for coverage under another group health plan or under Medicare. The individuals who become eligible under another group health plan or Medicare must notify the group health plan (COBRA administrator) or will be subject to tax penalties equal to 110% of the subsidy.

MCTWF will keep you informed of any additions, modifications or clarifications provided by the regulating federal agencies.

Mental Health & Substance Abuse Intensive Outpatient Treatments

Under MCTWF's Mental Health & Substance Abuse benefit, eligible patients are allowed 45 inpatient days, or their equivalent in intensive outpatient (IOP) treatments. Previously, the receipt of three non-residential IOP treatments would reduce available inpatient days by one. Effective January 29, 2009, the number of non-residential IOP treatments per each inpatient day has been increased from three to four. The number of residential IOP treatments per each inpatient day remains at two.

Customer Communications Department

We have focused our attention on our procedures for handling complex and time consuming participant inquiries and have concluded that the process can be made a good deal simpler and less stressful for participants, as well as more efficient for our staff. We presently are integrating the functions and tools of our two primary communications units, Customer Service and Correspondence, into a new *Customer Communications Department*. We trust that you will find this change to be beneficial.

For information on network providers, benefits and eligibility as well as for claim inquiries, contact the Customer Communications Department at 800-572-7687 or 313-964-2400.

Expansion of Preventive Dental Benefits

In the Fall 2006 issue of the *Messenger* it was announced that MCTWF's dental plans administered by Delta Dental had been expanded to provide preventive services for diabetics and pregnant women with periodontal disease, individuals with kidney failure or who are undergoing dialysis, those with suppressed immune systems due to chemo or radiation therapy, those with HIV or organ or bone marrow transplants and those undergoing head and neck radiation treatment, as those conditions can increase the risk for dental infections or decay.

Preventive services have been expanded further under those dental plans for covered individuals with certain heart conditions, by allowing four teeth cleanings per calendar year, either routine or periodontal, subject to annual benefit maximums. These heart conditions include -

- a history of infective endocarditis;
- certain congenital heart defects (such as having one ventricle instead of the normal two);
- artificial heart valves;
- heart valve defects caused by acquired conditions like rheumatic heart disease;
- hypertropic cardiomyopathy;
- pulmonary shunts or conduits; or
- mitral valve prolapse with regurgitation (blood leakage).

The dentist is responsible for submitting appropriate documentation of the existence of such condition in order for the claim for additional cleanings to be covered.

Covered Dental Services After Eligibility Ceases

Effective January 29, 2009, the Trustees extended coverage for certain dental services that commenced, but were not completed, prior to the loss of participant or covered dependent eligibility. The following procedures, if commenced while the participant or covered dependent is eligible, are now covered <u>if completed within 60 days of the date that treatment started</u>:

- the completion of dentures (full or partial) if the impression was made prior to the loss of eligibility;
- the completion of fixed bridgework, restorations and crowns if the tooth or teeth were prepared prior to the loss of eligibility; and
- the completion of root canal therapy if the tooth or teeth were opened for treatment prior to the loss of eligibility.

Delta Dental will initially deny the dentist's claim for these services. To have the claim reconsidered, the dentist then must resubmit the claim with a copy of the patient's chart to document that the date the treatment commenced was prior to the loss of the individual's eligibility. Delta Dental informs us that most network providers are aware of this policy.

Blue Distinction Centers for Transplants

The Blue Cross and Blue Shield Association maintains a national network of centers of excellence for specified organ transplants. This network, known as the Blue Distinction Centers for Transplants, is recognized for the extraordinary quality of care provided by its participating facilities. Those facilities were selected for participation, by transplant type, based on stringent, objective clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations, such as the volume of procedures performed, the duration of the transplant program, the transplant team's experience, the treatment protocols and the record of patient outcomes specific to the particular procedures. It is noted that although an institution may have satisfied the network's requirements for one transplant type, it may not have done so for other transplant types that it performs.

Presently, there are 80 participating facilities, representing more than 280 transplant programs, approved by the network to perform one or more of the following transplants: heart, liver, lung, simultaneous pancreas-kidney (SPK), liver-kidney, and heart-kidney. In Michigan, for instance, the network includes Children's Hospital of Michigan for pediatric heart transplants, Henry Ford Health System for liver, liver-kidney, SPK, and lung transplants (all adult) and the University of Michigan Medical Center for pediatric and adult heart, adult liver, adult liver-kidney, adult SPK and adult lung transplants.

Utilizing a center of excellence for a transplant, such as those in the Blue Distinction Centers for Transplants network, will increase materially the likelihood of a favorable outcome. To learn more, we refer you to the *Info Links* page of our website or directly at <u>http://www.bcbs.com/innovations/bluedistinction/blue-distinction-transplants/bluedistinctiontransplants.pdf</u>.

Retiree Medical Program Eligibility Rules

For those active participants considering or planning retirement, please take the time to familiarize yourself with MCTWF's eligibility rules for the Retiree Medical Program (Program).

ELIGIBILITY FOR CURRENT PARTICIPATION IN THE PROGRAM

Participants Age 57 or Older

- Must have participated in an eligible plan (i.e., one that includes Program benefits) and must have had contributions made on his behalf (i.e., eligible contributions) for at least 40 weeks in each of the five consecutive 52 week periods immediately preceding the Retirement Date (see DEFINITIONS, below), or at least 40 weeks in seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date; except that for periods while a participant performed seasonal work, eligible contributions must have been made for an average of at least 40 weeks per 52 week period for five consecutive 52 week periods immediately preceding the Retirement Date, or, an average of at least 40 weeks per 52 week period for seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date (the appropriate test shall be applied pro rata based on the type of work in which the employee was engaged during the measuring period).
- Must not be eligible for Medicare coverage.
- Must not be engaged in Prohibited Employment (see DEFINITIONS, below).

Participants Under Age 57

Effective January 1, 2005, a participant must be age 57 or older to commence participation in the Program, with the exception of "30-and-Out Pension" retirees, addressed below. All other participants age 50 through 56, who meet eligibility rules for age 57 or older (described above) and who seek to enroll in the Program must defer their Program participation to age 57 or older (see Automatic Deferrals, below).

"30-and-Out" Pensioners from a Teamster Pension Fund

- **Ages 50 to 56** – Must meet all of the eligibility rules for age 57 or older described above and must provide proof of "30-and-Out" pension.
- **Under Age 50** – Must meet all of the eligibility rules for ages 50 to 56 "30-and-Out" pensioners described above, with the exception that the Retirement Date is established based on employer contributions only (not on COBRA contributions; see COBRA Contributions, below). Participation is deferred (see Automatic Deferrals, below).

Restriction on Program Participation

Effective June 26, 2008, the right of participants to newly enroll in the Program is suspended upon the expiration of their collective bargaining agreement and will remain so unless the parties agree to renew participation in MCTWF, retroactive to the prior CBA's expiration date. In such case, the retiree's right to enroll is retroactively restored.

Enrollment and Self- Contributions

- To enroll in the Program, the retired participant must complete and submit to MCTWF the *Retiree Medical Program Application Form* within 90 days immediately following the Retirement Date .
- Retirees approved for Program participation must make self-contributions to MCTWF, as billed, in the amount established by the Trustees*****. Thereafter, self-contributions must be received on or before the 20th day of the month preceding the month for which coverage is provided.
  - ***** *Self-contribution rate amounts are reviewed annually and adjusted each plan year (commencing April 1st) based on the average trend rate experienced by the Program over the prior three years.*

COBRA Contributions

- **Age 50 or older** retiring participants may choose to make COBRA contributions to add to their years of MCTWF service and/or age (which will allow them to contribute at a lower rate).
- **Under age 50** retiring participants may not count COBRA contributions toward establishing their Retirement Date.

ELIGIBILITY FOR DEFERRED PARTICIPATION IN THE PROGRAM

Automatic Deferrals

- "30-and-Out Pension" retirees who are under age 50 and have completed and timely submitted the *Retiree Medical Program Application Form* and who qualify for Program participation, will be automatically deferred until age 50 or later. The retiree must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retiree at the commencement of coverage.
- Retiring participants who are age 50 to 56, who are not "30-and-Out Pension" retirees, and who have completed and timely submitted the *Retiree Medical Program Application Form* and who qualify for Program participation, will be automatically deferred until age 57 or later. The retiree must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retiree at the commencement of coverage.

Continued on page 5

Voluntary Deferrals

- Pre-Enrollment – Retired participants who have completed and timely submitted the *Retiree Medical Program Application Form*, and are approved for Program participation, may defer participation upon written request. The retiree must notify MCTWF at such time as he wishes to commence participation. The self-contribution rate will be calculated based upon the age of the retiree at the commencement of coverage.
- Post-Enrollment - Retired participants may defer coverage any number of times after commencement of participation in the Program, upon written request, subject to the requirement that the retiree must defer participation for no less than 12 months each time. At such time as the deferring retiree seeks to resume participation in the Program, the self-contribution rate will be the same rate fixed for the retiree at the time of deferral.

  If the deferral is for the purpose of resuming employment, there likely will be a period of time before eligibility is established for the new coverage (minimally eight weeks if it is with an employer that contributes to MCTWF). Therefore, the deferring retired participant may continue participation in the Program by making his monthly Program self-contribution until eligibility for the new coverage is established.

  If by virtue of active MCTWF participation during the deferral period, the deferring retiree can newly satisfy the initial eligibility rule of 5 out of 5 or 7 out of 10 years of MCTWF participation immediately preceding resumption of Program participation, the Program self-contribution rate will be recalculated to reflect the additional year(s) of service earned and the age of the retired participant at the time of Program resumption.

  Exceptions to 12-Month Rule

  - If the deferral is for the purpose of employment as a bargaining unit member by an employer that contributes to MCTWF for a plan that includes Program benefits, the 12 month minimum deferral period will be waived .
  - If the retired participant asserts to MCTWF that he is seeking to defer because he has coverage under another group health plan (for example, as a dependent under his spouse's plan), he may return to Program participation at any time thereafter, upon MCTWF's receipt of written documentation from the other group health plan that evidences the loss of coverage.

EXTENDED RETIREE SPOUSE COBRA DEFERRAL RULE

In the event that the spouse of a retired participant exhausts her right to continue participation in the Program at the Program's retiree self contribution rate, the retiree's spouse may continue participation in the Program as an Extended Retiree Spouse at cost-based rates (reviewed annually and adjusted each fiscal year by the Trustees), or may choose COBRA coverage instead. In the event that the retiree's spouse elects COBRA coverage, her right to participate in the Program as an Extended Retiree Spouse will be deemed deferred.

UNIFORMED SERVICES (MILITARY LEAVE) CREDIT

Uniformed Services credit may count toward satisfying MCTWF participation requirements (i.e., years of service) for establishing Program eligibility under the 5 out of 5 or 7 out of 10 year contribution rules (described above), and toward determining the Program self-contribution rate amount.

In order to earn up to five years of Uniformed Services Credit, all of the following conditions must be met:

- the participant must have entered the Uniformed Services while working for an employer that was making contributions to MCTWF (a Contributing Employer) on his behalf for a benefit plan that included Program benefits; and
- the participant's military leave does not exceed five years (except due to circumstances addressed in that section of USERRA entitled "Employment Rights of Persons Who Serve in the Uniformed Services"); and
- the participant applied for return to work with a MCTWF Contributing Employer within the following time frames:
  - within 90 days after completed duty time of more than 180 days; or
  - within 30 days after completed duty time of 31 to 180 days; or
  - within 5 days after completed duty time of up to 30 days.

DEFINITIONS

Prohibited Employment is defined as –

- employment, in any position, by an employer that contributes to MCTWF; or
- employment, other than government employment, in a position covered by a collective bargaining agreement between the employer and any affiliate of the International Brotherhood of Teamsters; or
- employment, including but not limited to self-employment, other than government employment, in the same industry in which the former employee was an active employee covered by MCTWF.

Retirement Date is defined as the date a participant ceases to be covered by MCTWF as an active employee as a result of retirement, after application of all remaining benefit bank weeks. However, for retiring participants age 50 or older, the purchase of COBRA coverage will extend their Retirement Date until the cessation of such coverage. For retiring participants under age 50, COBRA contributions will not extend their Retirement Date (see COBRA Contributions, above).

Retiree Medical Program Rates April 2009 - March 2010

Effective April 2009, the below listed self contribution rates will apply to all those participating in MCTWF's Retiree Medical Program:

Monthly Self-Contribution Rate Covering Both the Retiree and the Eligible Spouse*						
	Years Participating in MCTWF under a Plan with Retiree Medical Program Coverage					
Age at Retirement	**5 – 9**	**10 – 14**	**15 – 19**	**20 – 24**	**25 – 29**	**30 +**
50 – 54	$590	$535	$480	$435	$370	$325
55 – 59	$455	$420	$390	$355	$330	$300
60 - 64	$325	$310	$300	$290	$280	$270
For Eligible Retirees whose active employment ceased prior to January 1, 2002 $270						

Participants contemplating retirement should refer to MCTWF's Retiree Medical Program Eligibility Rules (see pages 4 and 5 hereof).

***** A spouse's eligibility to participate in the Program ceases when the spouse becomes eligible for Medicare Part A coverage. In the event that the retiree dies, or turns age 65 and is therefore eligible for Medicare Part A prior to the spouse's Medicare eligibility, 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 until the spouse becomes eligible for Medicare Part A.

Prior Authorization for Proton Pump Inhibitors

MCTWF's current rule for coverage of prescription proton pump inhibitors (PPIs) requires prior authorization from MCTWF's Utilization Review Department based upon -

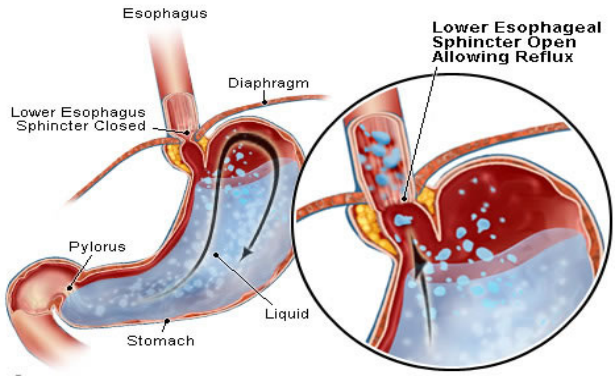
- documented failure of treatment (minimum of eight week trial) with Prilosec O-T-C; or
- an adverse reaction or intolerance to Prilosec O-T-C; or
- an adverse interaction or potential adverse interaction with Prilosec O-T-C.

Effective April 1, 2009, in addition to satisfying one of the above criteria, full coverage for prescribed PPI medications (subject to 90 day retail or mail order copays only; 30 day copays are not available for PPIs), will be contingent upon the prescribing physician's documentation of the existence of esophagitis or a complication caused by that condition (e.g., esophageal narrowing, esophageal ulcer, or Barrett's esophagus). Otherwise, MCTWF coverage will be limited to 15% of charges (i.e., the patient will be responsible for 85% of charges; the charges, of course, will be at the discounted rate negotiated by MCTWF through Caremark), except for generic Omeprazole which will be covered in full, subject to the 90 day copay.

Those with current PPI authorizations have been informed by mail that they will continue to be covered until their authorization expiration date, but by no later than the last day of the month in which their birthday falls in 2010. However, effective April 1, 2009, they too will be subject to the new 90 day copay requirement.

PPIs are the most effective medications for reducing the production of stomach acid, which can flow back (reflux) into the food pipe (esophagus) when the valve between the stomach and the esophagus weakens or abnormally relaxes. This condition, which is known as GERD (gastroesophageal reflux disease), can cause symptoms such as heartburn, sore throat, and regurgitation of food or sour liquid. Factors that may contribute to GERD include smoking, being overweight or pregnant, the consumption of fatty or spicy foods, chocolate, caffeine, onions, tomato sauce, mint, alcohol, large meals, lying down soon after eating, and medications including sedatives, tranquillizers, and calcium channel blockers (for high blood pressure). Consequently, GERD can often be treated successfully with a combination of lifestyle changes and the short term use of Prilosec O-T-C.

However, if left untreated, GERD can progress into esophagitis, in which the esophagus becomes inflamed, or into more serious complications. In such cases, long term treatment with a prescription PPI may be deemed medically necessary.



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 2008 *Recommended Adult Immunization Schedule* remains unchanged and can be accessed from the Spring 2008 issue of the *Messenger*. The annual adult flu vaccine is covered in full if received from a network provider.

Below is the *2009 Recommended Child and Adolescent Immunization Schedule.* Please take note that the annual influenza vaccination is now recommended for all children ages 6 months through 18 years; previously it was recommended for children ages 6 months to 5 years. All recommended child and adolescent immunizations are covered in full if received from a network provider.

2009 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			Hib	Hib	Hib	**Hib**								
Pneumococcal			PCV	PCV	PCV	**PCV**				**PPSV**				
Inactivated Poliovirus			IPV	IPV	**IPV**						**IPV**	IPV Series		
Influenza					**Influenza (annually)**									
Measles, Mumps,						**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

Blood Pressure Monitors

Previously, MCTWF medical plans covered the prior authorized purchase of physician prescribed, automatic blood pressure monitors for eligible individuals with a medical diagnosis of chronic kidney disease or end stage renal disease, when the monitor is obtained from a Blue Cross Blue Shield certified durable medical equipment (DME) supplier.

Effective January 29, 2009, the rule is changed to cover the purchase of automatic blood pressure monitors for *any* medical diagnosis, limited to one new monitor once every 36 months.

Your DME supplier must obtain prior authorization from MCTWF prior to the purchase of the monitor. The prior authorization request should be accompanied by a letter of medical necessity from the prescribing physician and submitted to MCTWF's Utilization Review Department.

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 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.

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

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE
PAID
DETROIT, MI
PERMIT #2655

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

2700 TRUMBULL AVE.
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 MCTWF	800-637-6907
For Delta Dental or DeltaVision	800-524-0147
For BCBSM	800-482-3787

Benefit Bank Weeks Renewal

We are pleased to announce that the Trustees have renewed MCTWF's standard benefit bank week provision for eligible medical plans for the 36 month period beginning April 1, 2009 as follows:

- Participants who are actively employed as of that date, and on whose behalf company contributions are being made, will be allotted six benefit bank weeks for use during the period April 1, 2009 through March 31, 2012.
- Participants who are not actively employed as of that date and who are using their remaining prior period benefit bank week allotment may continue to use those remaining weeks until their return to active employment. Upon their return to active employment, these participants will be allotted six benefit bank weeks through March 31, 2012.
- Participants who are not actively employed as of that date, and who have exhausted their prior period benefit bank week allotment will receive, upon their return to active employment or if later, upon their re-establishment of eligibility for active benefits, a six benefit bank week renewal through March 31, 2012.
- Bank week benefits are limited to the related plan's medical and prescription drug benefits. Accordingly, as is currently the case, no optical, dental, short term disability ("loss of time"), total and permanent disability, or death benefits will be available when incurred during benefit bank weeks.

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