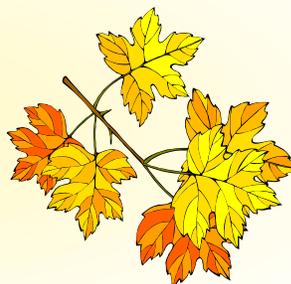


Michigan Conference of Teamsters Welfare Fund

Messenger



VOLUME 19, ISSUE 3

FALL 2001

Message from the Fund's Executive Director, Richard Burker

With your indulgence, we take some license in naming this belated issue *Fall*, as the trees have fast become barren and as the nation is already turning its weary eye to the approaching holiday season for a much needed respite and self embrace.

Despite our having been slapped awake into a new reality, with much to learn and consider about ourselves and our futures, the Fund's staff have worked so conscientiously, with such dedication to the principle of doing good by doing well during this period, that I feel it appropriate to publicly thank them and express my respect for them.

The *Fall* issue of the *Messenger* focuses on a number of matters affecting your benefit limits, your out-of-pocket costs and rules governing your participation. Of significance to most participants is the change for 2002 in the **prescription drug co-payment structure**, distinguishing between generic and brand name drugs and between retail and mail service fills, as well as the change in the Fund's mail service pharmacy benefit manager. Also affecting many participants are new rules regarding **Retiree Medical Program** participation and new **Affinity Rx Program** contribution rates. Another article urges the use of **dental procedure predeterminations** particularly in light of the annual \$2,500 per person per calendar year limit on dental benefits commencing in 2002. Participants are alerted to the **closing of enrollment windows** at year end for participation in the **Fund's Retiree Death Benefit and Flexible Dependent Coverage Programs**. Also of note is the Fund's replacement of its **behavioral health network** and the Fund's adoption of **organ transplant benefits for Retiree Medical Program participants**.

On behalf of the Fund's staff and Board of Trustees, I wish you and your loved ones the very warmest, safest and happiest winter holiday and best wishes for the new year.

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New Summary Plan Descriptions

By now you should have received your newly formatted and updated Summary Plan Description and a Schedule of Benefits. We trust that you'll find your Plan documents comprehensive and easy to use. The Summary Plan Description provides a detailed explanation of your Plan benefits and all other information necessary for your participation. The Schedule of Benefits highlights your benefit options and limits, including your payment schedule, co-payments, deductibles and important telephone numbers.

As modifications are made to your Plan, they will be reflected in the *Messenger*. Please keep each edition of the *Messenger* together with your Plan documents as a complete reference source, until the Fund next updates your Summary Plan Description.

Retiree Medical Program Human Organ Transplant Benefit Addition

As announced in the *Fall 2000* issue of the *Messenger*, retirees who continuously participate in the Retiree Medical Program following the commencement of Phase I transplant services (pre-transplant evaluation), may continue active transplant benefit coverage until their maximum active transplant benefits are exhausted, or until they cease participation in the Retiree Medical Program. To date, however, transplants have not been covered as a benefit under the Retiree Medical Program when participation in the Retiree Medical Program precedes the commencement of Phase I transplant services.

Effective September 1, 2001, the Fund has added Human Organ Transplant Benefits to the Retiree Medical Program.

The transplant benefits under the Retiree Medical Program apply to retirees who commence participation prior to beginning Phase I transplant services. **These benefits are subject to the Retiree Medical Program's all-inclusive, per person calendar year maximum of \$150,000.** This means that once the \$150,000 annual limit is met, no further benefits will be available for any condition in that calendar year. For detailed information, please contact the Fund's Member Services Department.

Dental Program

In the *Summer 2001* issue of the *Messenger*, the Fund announced that its Dental Plan and Dental & Optical Plan I had been amended, effective January 1, 2002, to limit dental benefits for services rendered in any calendar year to a maximum of \$2,500 per person. This limitation will be strictly applied to all dental procedures, other than orthodontics, whether or not predetermined.

In order to ensure that intended dental services are covered under your plan of benefits and to ensure that you understand any financial exposure you may have, the Fund recommends predetermination of all dental procedures in excess of \$200 in charges, whether or not your

dentist participates in the Delta Dental network.

Here's how it works. Your dentist submits his or her treatment plan to the Fund in advance. The treatment is reviewed and you and your dentist are informed of what is deemed covered, what your Plan pays and how much you will have to pay. Your predetermination may also suggest alternate courses of treatment. If for some reason you do not receive the treatment within 90 days, or the treatment plan changes, a new predetermination is recommended.



Retiree Death Benefit Program Enrollment

Initial open enrollment into the Retiree Death Benefit Program is coming to a close. As announced in a July, 2001 Program mailing, as well as the *Summer 2001* issue of the *Messenger*, the Fund will be accepting applications from retirees and/or their spouses until the later of December 31, 2001 or 90 days following their retirement date. Beginning January 1, 2002 we will be accepting applications only from those who retire no more than 90 days prior to the date of their application to enroll. **If you plan on taking advantage of the open enrollment period, we must receive your application by December 31, 2001.**

Retiree Medical Program Eligibility/Contribution Rate Rules

The Effect of COBRA Contributions

In the *Summer 2001* issue of the *Messenger* we sought to further explain the Fund's definition of "Retirement Date" to aid you in your retirement planning. The Retirement Date is key to establishing your eligibility for Retiree Medical Program enrollment. It is also key to determining your age/participation based contribution rate if your Retirement Date is after December 31, 2001.

In so explaining, however, we failed to restate the Fund's rule that, while COBRA contributions following a participant's last date of contributed-for employment will extend his Retirement Date, that is so only for those who are age 50 or older on their last date of contributed-for employment. Thus, a participant under age 50 still cannot satisfy the Fund's minimum age 50 requirement for Retiree Medical Program eligibility by making COBRA contributions through his 50th birthday.

The Effect of Deferrals

In addition, the Fund has adopted new rules regarding the effect of deferrals, for post December 31, 2001 retirements, on Retiree Medical Program contribution rates. In the event of a deferral (either by under age 50 "30-and-out" retirees, or by age 50 and older retirees with other insurance coverage), the commencement date of Program participation will govern for age based contribution rate determination. For example (assuming that the schedule of post 12/31/01 rates is unchanged), you retire at age 50 with 20 years of Fund participation and are deemed eligible to participate in the Program at the monthly rate of \$220 but you choose to defer participation due to coverage under your spouse's benefit plan. Five years later you lose such coverage and elect to participate in the Program. Your monthly contribution rate, based on your 20 years of Fund participation and your then age of 55 would be \$170.

The Effect of Central States Welfare Fund Participation

The Fund has adopted a new rule regarding the effect of Central States Southeast and Southwest Areas Health and Welfare Fund participation in calculating years of Fund participation for Retiree Medical Program contribution rate determination for post December 31 2001 retirements. The Fund has decided to recognize all years of participation in the Central States Welfare Fund. Each such year must be comprised of at least 40 weeks of contributions. However, under no circumstances will Central States Welfare Fund participation be used to substitute for years of participation in this Fund necessary to meet minimum eligibility requirements of the Program. For example, you participated in the Central States Welfare Fund from 1985 to 1990, followed by 10 years of coverage under a commercial insurance plan and then commenced participation in this Fund in 2000 at the age of 50. You will not be eligible to enroll in the Fund's Retiree Medical Program until you satisfy the Fund's requirement of 5 years of contributions in the 5 years immediately preceding your retirement date (or 7 years in the 10 years immediately preceding your retirement date). Once you do, however, your required contribution rate will reflect your years of participation in both Funds (for this example, 5 years in Central States Welfare Fund plus 5 years in this Fund).

Please contact the Fund's Retiree Department at least two months prior to your retirement date so that we may have ample time to verify eligibility for the Program and respond appropriately.

Behavioral Health Network

Effective January 1, 2002, the Fund will cease operation of its behavioral health network and replace it with Value Options, Inc. ValueOptions will be the network provider of services for all mental health and substance abuse treatment, both inpatient and outpatient. ValueOptions has been providing prior authorization and case management services to the Fund for years in connection with the Fund's behavioral health program.

ValueOptions is the largest privately held behavioral health managed care company in the nation, and the second largest managed behavioral healthcare company overall. In Michigan alone, its network is comprised of about 230 inpatient facilities, 670 clinics and 650 individual behavioral health professionals.

All inpatient and outpatient services, as before, must first be prior authorized by ValueOptions. **This is also true, for the first time, for Fund Retiree Medical Program participants.** Simply call 1-800-457-8540 and a qualified expert will assist you and direct you to the appropriate network provider. You still have the option of seeking professional help from an out-of-network provider but, as detailed in your Summary Plan Description, your out-of-pocket costs will be greater.

In the event that the Fund identifies a participant currently utilizing a Fund network provider who is not also part of the ValueOptions network, the participant will be contacted by the Fund to arrange for a reasonable transition period or the recruitment of that provider by ValueOptions.

Flexible Dependent Coverage

The Flexible Dependent Coverage Program allows participants to waive dependent medical and prescription drug coverage if they have no dependents, or if their dependents have such coverage through another plan. In return, participants are provided with a Medical Spending Account, which credits \$45 for each full month of Program participation. Credited sums may be used to reimburse most medically related expenses.

If you wish to participate in this Program, you must first fill out the Fund's Flexible Dependent Coverage Election Request form and send proof of dependent coverage. The form and information on the Program can be obtained by contacting the Member Services Department.

These documents must be received by the Fund on or before December 31, 2001. A determination of your eligibility and notification to you will be made in writing no later than January 31, 2002. The general enrollment window will not re-open for another 12 months, although you may enroll at any time if you make timely application following a change in family status. Your participation will continue from year to year until you send written notification to the Fund stating you no longer wish to participate.

Communications to the Fund

Please be advised that the Fund will not accept address changes over the telephone. Notification of address changes must be mailed or hand delivered to the Fund.

Also, when sending any type of correspondence to the Fund, always include the participant's social security number.



Non-Access to Network Providers

The Fund allows participants to apply for a non-access exemption when an in-network primary care or dental provider is further than 20 or 25 miles, respectively, from their home. However, given the rapid expansion of the Fund's medical and dental networks, your exemption may not continue to be appropriate.

Therefore, if your application is approved, that approval will continue for six months from the date that first non-access services are rendered. Any services beyond the six month period must be approved for continued exemption through a new application.

Prescription Drug Benefit Programs

This article will address changes in the co-payment structure for each of the Fund's prescription drug benefit programs, the new Affinity Rx Program contribution rates and the Fund's change in its pharmacy benefit manager for mail service prescription drug purchases.

The Fund has maintained its prescription drug co-payment levels since each program's inception. The Fund has actively overseen its pharmacy benefit managers to ensure their strict monitoring of drug pricing rules, aggressive reviews and refund entitlements from drug vendors and their efforts to educate and effectively use incentives to encourage the use of generic equivalent drugs. Yet ever increasing utilization and price of prescription drugs, primarily driven by an explosion of heavily marketed, expensive brand name drugs, has resulted in a 25% annual growth trend in the Fund's prescription drug costs. Generic drug utilization is falling well short of realistically achievable levels. The Fund is seeking to reach appropriate generic drug utilization levels through a combination of education and co-pay incentive.

While there is not always a generic equivalent available, about 9,000 of the 10,000 brand name drugs on the market today have generic equivalents, usually costing less than half, and often just a small fraction, of their brand equivalent. It is not generally known that generics must meet the same standards for purity, strength and quality as brand name drugs, with the same active ingredients absorbed into the body at the same rate and manner, producing the same results.

Effective January 1, 2002, the current co-pay requirement for all prescription drug purchases, both retail and mail order, will change. Retail co-pays for generics will remain unchanged, but brand name co-pays will be increased. Mail service co-pays for purchases in excess of 34-day supplies will be twice those of retail co-pays. **The following chart reflects the new co-payment structure for all Plans:**

Prescription Filled As	Plans With Previous \$5.00 Co-pay		Plans With Previous \$10.00 Co-pay		Retiree Medical Program		Affinity Rx Program	
	January 1, 2002 Retail Prescription Program Co-payments							
Generic Drug	\$5.00		\$10.00		\$5.00		\$5.00	
Brand Name Drug	\$15.00		\$20.00		\$15.00		\$15.00	
Dispense As Written (DAW)	\$15.00		\$20.00		\$15.00		\$15.00	
Brand Name Drug, No Generic Available	\$15.00		\$20.00		\$15.00		\$15.00	
Participant Refuses Generic Equivalent When Available	\$5.00 + Dif		\$10.00 + Dif		\$5.00 + Dif		\$5.00 + Dif	
Prescription Filled As	January 1, 2002 Mail Service Prescription Program Co-payments							
	1-34 Day Supply	35-90 Day Supply	1-34 Day Supply	35-90 Day Supply	1-34 Day Supply	35-90 Day Supply	1-34 Day Supply	35-90 Day Supply
Generic Drug	\$5.00	\$10.00	\$10.00	\$20.00	\$5.00	\$10.00	\$5.00	\$10.00
Brand Name Drug	\$15.00	\$30.00	\$20.00	\$40.00	\$15.00	\$30.00	\$15.00	\$30.00
Dispense As Written (DAW)	\$15.00	\$30.00	\$20.00	\$40.00	\$15.00	\$30.00	\$15.00	\$30.00
Brand Name Drug, No Generic Available	\$15.00	\$30.00	\$20.00	\$40.00	\$15.00	\$30.00	\$15.00	\$30.00
Participant Refuses Generic Equivalent When Available	\$5.00 + Dif	\$10.00 + Dif	\$10.00 + Dif	\$20.00 + Dif	\$5.00 + Dif	\$10.00 + Dif	\$5.00 + Dif	\$10.00 + Dif

Dif = Difference in cost between Generic and Brand

Each year the Fund considers whether to renew the heavily subsidized Affinity Rx Program for Medicare eligible retirees. The Fund is pleased to announce that the Program has been renewed for 2002. The required contribution rate schedule has been modestly increased by 10%, effective April 1, 2002, representing the first increase since the Program's April 1, 1999 inception. The new schedule is posted below. Participants will be individually notified of their new rates.

Years of Participation	05—10	11—15	16—20	21 plus
Monthly Rate Per Person	\$19.80	\$17.60	\$15.40	\$11.00

Also effective January 1, 2002, mail service prescriptions will be filled by Merck-Medco Rx Services through its business partnership with Blue Cross Blue Shield of Michigan. Therefore, requests for new prescription fills and refills must be submitted to Express Scripts by December 31, 2001. Express Scripts will honor your refill request after 70% of your current supply has been exhausted. So, for example, you may request a refill of a 90 day supply after 63 days (i.e. 27 days prior to exhaustion of your current supply). You will be receiving your Merck-Medco mail service information packet shortly. Please note that refillable prescriptions which have been provided to Express Scripts will have to be replaced.

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**Fund Tip From the
Correspondence Department**

Most Fund Plans cover emergency room treatment for accidental injuries and life threatening medical emergencies that are not related to or caused by your job or that are not auto-related. If a claim for emergency room treatment for you or your dependent is rejected, you will receive an explanation of benefits from BCBSM. **If you send your rejection to the Fund for review, please remember to also include a copy of the emergency room report.** In doing so you will speed up the process of reviewing your claim.

**Happy Holidays!!
From the Correspondence, Recovery
and Claims Departments**



(Top Row) Kathy, Sandy, Mona, Jan, Vinita, Jean
(Middle Row) Mary, Sue, Willie Mae, Sally, Janice, Denise, Tom
(Bottom Row) Debbie, Kim, Diane, Kristi