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MESSENGER

The Michigan Conference of Teamsters Welfare Fund

Understanding Your Benefits

QUESTIONS AND ANSWERS

Here at the Fund we have an entire department dedicated to answering your questions to help you better understand your Health and Welfare benefits. Since we know your time is valuable, we thought we might save you time on the telephone by communicating to you some commonly asked questions and their answers.

Q: *Why are my children and/or spouse not listed as covered under my health and welfare plan?*

A: When you become eligible for benefits provided by the Fund you will receive an enrollment card. By filling out the dependent section of the card, this lets us know what dependents should be covered, as long as they fall under the eligibility rules . Also, if your marital status changes or dependents should be added you should contact the Fund office to obtain a new enrollment card to ensure those changes are reflected on your coverage.

Q: *I need to utilize the psychological or substance abuse benefits available to me through my benefit plan. What is the first step I take in order to do so?*

A: All active inpatient and outpatient treatment for nervous, mental and substance abuse require prior authorization. The first step you must take is to call the Teamsters Confidential Help Line number to receive a referral and prior authorization at 1-800-457-8540

Q: I have SOA benefit coverage and am in need of eye glasses. What is covered under my vision benefits?

A: Under the SOA plan, your vision benefit allows you to visit the provider of your choice, who will be paid according to the Fund's Schedule of Benefits. Each eligible family member can utilize this benefit every 12 months.

Q: *I am moving. Do I need to contact the Fund to let them know?*

A: Yes, in fact, any family status changes such as marriage, divorce, death, birth, adoption, change in your spouse's employment, or any event wherein a dependent is added or deleted, should be sent to the Fund office in writing and should include any applicable legal documentation.

Q: *I have a question regarding my pension. Who do I contact?*

A: The Fund does not administer pension benefits. If you have Central States pension coverage and are in need of assistance please call 1-800-323-5000.

Q & A

Inside this issue:

Claim Filing Limitations

Effective April 1, 1999 an Amendment was made to the Claims filing limitation. This was created to promote faster and more efficient resolution of claims. This amendment states that all claims for benefits MUST be filed with the Fund office within one (1) year of the event or date of service of the benefit.

Medical, dental, vision and prescription drug claims, services rendered on or after April 1, 1999 must be filed with the Fund within one year after the date of service.

Claims for death, accidental death and dismemberment that occur on or after April 1, 1999, must be filed with the Fund within one year after the date of death or dismemberment.

Disability claims that occur on or after April 1, 1999 , must be filed with the Fund within one year after the disability occurred.

Claims for benefits that occurred prior to April 1, 1999 remain subject to the two (2) year filing limitation.

THE APPEAL PROCESS

Occasionally, there are times when a participant's benefit claim is denied. In such cases you receive an explanation of why the claim was denied within 90 days of its receipt.

The Fund's "Appeal Process" allows participants to dispute the claim denial. If you are unable to determine whether or not there is a need to file an appeal, i.e. the claim is denied due to improper information submitted, please call the Member Services Department at ext. 430. They will help you make that determination.

Here is how the appeal process works:
The participant submits a written request and any pertinent information, for the claim to be reviewed to the Board of Trustees, within 60 days of receiving the claim denial.

The Board of Trustees will review the appeal and will act upon it within 60 days of its receipt. If the Board decides a hearing needs to be held, they have 120 days maximum from the receipt of the appeal.

The Trustees recently adopted a new policy. If additional information from the participant is necessary in order to fully review the appeal, the Fund will request it in writing. The participant has 90 days to respond to the Fund's inquiry. If the Fund does not receive a response within 90 days, the decision made by the Board will be based upon the information in the file at that time.

The Participant will then be notified in writing the action the Board decided upon and the basis for their decision.

Participants are required to exhaust this procedure before commencing legal action against the Fund.

Please remember: include the participant's social security number with all correspondence to the Fund, including faxes.

Laboratory Services Program

In Mid August, 1999 a letter was sent out to all participants regarding laboratory claims processing. In this letter we indicated Laboratory Services Program can no longer service our members or process their laboratory claims.

Process their laboratory claims.

Just as a reminder, *PLEASE DO NOT SEND YOUR LABORATORY BILLS TO UNIVERSAL STANDARD LABORATORY OR CALL THE PHONE NUMBER PUBLISHED IN THE JULY ISSUE OF THE MESSENGER. PLEASE FORWARD THEM TO THE WELFARE FUND* at 2700 Trumbull—Detroit, MI 48216, Attention Lab Claims.

All participants will be notified as soon as lab processing changes are available.

Retiree Surviving Spouse Coverage Five Year Rule

The Fund's Surviving Spouse program offers coverage to the participant's spouse once the member's retiree coverage is terminated. Under the program the retiree's spouse is entitled to a maximum of 5 years of coverage beginning when the participant retires. If the retiree dies or attains the age of 65 before the spouse has received 5 years of coverage, the spouse can continue coverage at the $50 per month rate for the balance of the 5 years beginning with the participants retirement date, and including any waiver period.

After surviving spouse coverage has exceeded the 5 year period, the spouse will be given the opportunity to pay for coverage at the higher rate until he or she reaches the age of 65 or becomes eligible for Medicare.

The amount paid is determined annually, but can be obtained by calling the Member Services department at extension 430.

Second and Third Opinions

At times participants feel it is necessary to obtain a second or third opinion on a medical treatment or surgical procedure. The Trustees of the Welfare Fund have announced that they will be increasing payment to the physician providing the opinion or advice by paying reasonable and customary allowances for the level of consultation. No deductibles or copayments will be charged.

Diagnostic lab tests and x-rays shall still be considered up to the reasonable and customary level of reimbursement.

Please be aware that payment is made for these services only to the physician providing the consultation for an opinion and/or advice, even if the participant does not follow the recommendations .

Plan A participants may obtain a second or third opinion from a non-participating provider, but the course of treatment or surgery must be performed by a Plan A provider. You should consult with your primary care physician, or you may call the Fund for a referral to a Plan A specialist at extension 430.

Subrogation of Benefits/Third Party Liability Claims

The Trustees of the Fund recently adopted a revised subrogation provision with regard to third party liability claims ("Subrogation" means to stand in the place of another.)

If you or your eligible dependent incur medical expenses as a result of a negligent third party, the Fund is entitled to reimbursement from amounts recovered from the third party. (Example: You may have fallen in a grocery store due to a slippery floor, or tripped over an obstacle in the aisle) The Fund will ask you to sign a Subrogation Agreement, agreeing to reimburse the Fund amounts recovered in the lawsuit.

Participants must notify the Fund of their intention to sue a third party by the later of (a) 45 days after the accident or injury or (b) 45 days after the participant notifies a third party of intent to sue.

As stated above, the Fund will ask the Participant to sign a Subrogation Agreement. If a participant refuses to sign the agreement, then the Fund will reduce the amount of future benefits it pays by any amount that the Participant recovers in the lawsuit until the Fund has been reimbursed for medical benefits it has paid.

If you have any questions regarding the subrogation provision, please call Members Services at extension 430.

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313-964-2400
Metro Detroit 1-800-572-7687
Upstate Members 1-800-824-3158
Out-of-State 1-800-334-9738

FUND TIP

PLAN A MEMBERS

If your Plan A primary care physician believes it is necessary to refer you to a specialist, the specialist must participate in our Plan A program, unless comparable services cannot be rendered within the Plan A network and within a reasonable geographic distance. You must contact the Fund office to verify that the specialist is a Plan A provider, BEFORE services are rendered. Unnecessary and inappropriate referrals defeat the purpose of the Plan A program, and can result in nonpayment by the Fund for services rendered.