

Michigan Conference of Teamsters Welfare Fund

Messenger



VOLUME 20, ISSUE 2
SPRING 2002

Message from the Fund's Executive Director, Richard Burker

Late Spring. Beautiful Michigan, my adopted home, blooms with life and the optimism born of this season of renewal. The kids are home from school, a lot taller than last summer and hopefully a little smarter, bursting with hungry anticipation of new summer adventures. Special greetings from the Fund's staff and Trustees to all the wonderful Teamster kids. Let's keep them safe and healthy and happy. They are the future.

Our lead article in this issue describes a new benefit just approved by the Fund's Trustees, the "Out-of-Town Urgent Care Benefit", which limits out of pocket exposure for participants who are traveling away from home.

Having no other benefit or rule changes to review for this issue, we have taken the opportunity to address some items which are the source of many requests for clarification. We have included a comprehensive review of the Fund's often challenging Explanation of Benefits form (which, by the way, we are planning to replace with a customized version by this time next year). We have attempted to explain how the Coordination of Benefits rule works, as well as to clarify the Auto Exclusion rule. Also provided are important reminders for establishing eligibility for the Fund's Retiree Medical Program (for under age 50, "30 and out" retirees) and Mental Health and Substance Abuse benefit. We have also taken the opportunity to raise the extremely sensitive and important matter of childhood depression and its connection to alcohol and drug use. Finally, for those of you who count yourselves among the smokers who are ready, or just about ready to quit, please give careful consideration to Dr. Elliotte Moss' article "Okay, It's Really Time...".

Best wishes for a great summer.

New Out-of-Town Urgent Care Benefit

Apart from instances where a participant is deemed not to have reasonable access to network primary care physicians, or in the case of emergencies involving life threatening or significantly worsening medical conditions, the Fund has required participants to pay applicable deductibles and coinsurance when medical services are obtained from out-of-network providers.

The Fund has amended this rule in recognition that there are instances when a participant is away from home, experiencing an urgent medical condition requiring immediate attention and is unable to locate a network provider. Accordingly, in such circumstance, when urgent care is required and the Fund office is not open to direct you to a local network provider, so long as services are not obtained from a hospital emergency room (such services are only covered in the case of an emergency), the Fund will waive out-of-network deductible and coinsurance payments for urgent care services obtained from an out-of-network provider. The participant will, of course, be liable for any provider charges in excess of the Fund's reasonable and customary allowance (as well as any in-network deductible and/or coinsurance payments which may be required). This rule change applies only to urgent conditions and therefore does not apply to follow-up services. Appropriate documentation will be required to determine eligibility and the medical records will be reviewed by the Fund's Medical Director for determination of whether an urgent condition existed. Please contact the Fund's Member Services Department for more details.

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Understanding the Fund's Medical & Optical EOB

The Fund's Explanation of Benefits (EOB) provides you with key information regarding the disposition of your medical and optical claims. **The EOB is not a bill.** The Fund encourages your review of the EOB to ensure that the services billed for were actually performed and that your claim was processed consistent with your plan of benefits. Provided below are category descriptions.

The top section of the EOB contains general participant (member) and patient information including the member's name and social security number, the patient's name and the claim number, which will be requested by our Member Services Department consultant if you seek information regarding your EOB.

The middle section of the EOB contains the:

- **Provider** - the name of the health care professional or facility providing the services.
- **TOS** (Type of Service) - the Fund's code for the type of service received, detailed below.
- **Date of Service** - the date the services were rendered by the provider.
- **Total Charges** - the total amount the provider charged for the service(s).
- **Basic Allowed** - that portion of Total Charges, payable by the Fund, for other than Major Medical benefits prior to the application of co-payments, COB or Other Adjustments.
- **Major Medical** - benefits which are subject to deductibles and coinsurance payments.
 - **Allowed** - that portion of the Total Charges payable by the Fund prior to the application of deductibles, coinsurance, COB or Other Adjustments.
 - **Deductible** - a portion of the allowed amount payable by the member; usually an annual amount.
 - **%** - the percentage of the Allowed amount, payable by the Fund, after application of the deductible.
 - **Benefit** - the amount payable by the Fund after the application of deductibles and coinsurance, and prior to COB or Other Adjustments.
- **Total Benefit** - the total amount payable by the Fund prior to the application of COB or Other Adjustments. The Total Benefit equals either the Basic Allowed minus any co-payment, or the Major Medical Allowed minus any deductible or coinsurance amount.
- **CD** (Code Description) - the code for the disposition of the claim under Remarks in the bottom section of the EOB.
- **Type of Service Code Description** - a description of the TOS code.
- **COB Adjustments** - this field does not reflect the amount which its name suggests and should be ignored. Please see our *Coordination of Benefits* article on Page 5 of this issue.
- **Other Adjustments** - any other adjustment to the Total Benefit (e.g. deduction for overpayment).
- **Total Payment Amount**
- **Paid to Member**
- **Paid to Provider(s)**
- **Non-Covered** - the total charges that exceed the Basic Allowed or Major Medical Allowed amount. *
- **Paid by Other Carrier** - the amount payable by the primary plan pursuant to the coordination of benefits provision of the plan.

The bottom section of the EOB contains the:

- **C.D./Remarks** - an explanation of the Code Description stated in the middle section of the EOB.


If you have difficulty understanding your EOB, please do not hesitate to contact the Fund's Member Services Department.

* The Non-Covered category generates the most frequently asked questions because participants are often unsure as to whether they are responsible for the payment of the amount stated. Due to system limitations, this category is used for a variety of reasons, two of which are addressed below. For each line of the claim that has a non-covered amount, there will be an explanation in the *Remarks* section at the bottom of the EOB.

Below are the two *Remarks* regarding non-covered amounts that generate the most questions:

Remark NZ: *Claim payment is based upon PPOM contracted allowances. This payment, along with the patient's responsibility, constitutes payment in full.* In this case, the amount charged in excess of the sum that the provider has agreed to accept as a PPOM provider is reflected in the Non-Covered field. The participant is not responsible for payment of this excess amount. However, the participant remains responsible for any applicable co-payments, deductible or coinsurance amounts.

Remark C1: *The charges submitted exceed the plan reasonable and customary allowance for the services rendered.* In this case, the amount charged in excess of the reasonable and customary sum payable under the Fund's plan of benefits for out-of-network providers is reflected in the Non-Covered field. The participant is responsible for this excess amount if the out-of-network provider bills the participant for the balance. The participant remains responsible for any applicable deductible or coinsurance amounts.

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND										2700 Trumbull Avenue Detroit, Michigan 48216	
EXPLANATION OF BENEFITS THIS IS NOT A BILL											
THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) GIVES YOU THE RIGHT TO REQUEST REVIEW OF ANY CLAIM DENIED IN FULL OR PART. TO REQUEST THIS REVIEW YOU MUST SUBMIT YOUR REQUEST IN WRITING TO THE FUND OFFICE WITHIN 60 DAYS OF THE DATE SHOWN ON THIS NOTICE											
DATE				PATIENT'S NAME							
MEMBER INFORMATION				MEMBER SOCIAL SECURITY NO.				PATIENT'S NO.			
CLAIM NO.											
SAVE FOR YOUR TAX RECORDS. THIS INFORMATION WILL NOT BE REPRODUCED OR DUPLICATED.											
PROVIDER	TOS	DATE OF SERVICE	TOTAL CHARGES	BASIC ALLOWED	MAJOR MEDICAL				Total Benefit	C	D
					ALLOWED	DED.	%	BENEFIT			
Type of Service Code Description		Totals									
										C.OB. ADJUSTMENTS	
										OTHER ADJUSTMENTS	
										TOTAL PAYMENT AMOUNT	
										PAID TO MEMBER	
										PAID TO PROVIDER(S)	
										NON-COVERED	
										PAID BY OTHER CARRIER	
C.D.		REMARKS									
											

Okay, It's Really Time to Commit to Quit

Statistics are quite clear in pointing to obesity and tobacco use as the two most significant but reversible threats to your good health. Consistent with its commitment to preventative health care and the general well being of its participants, the Fund seeks to promote the cessation of smoking as an integral part of its Wellness Program.

Cigarette smoking is the most significant user controllable source of improved health status. Approximately one-half million Americans die each year due to smoking and other tobacco related diseases (stroke, heart attack, emphysema, and lung cancer). If you still use tobacco in any of its various forms (cigarettes, cigars, chewable products, etc.), we urge you to consider the evidence and to commit to a program of cessation.

This article discusses an overall approach to smoking cessation. The following steps are suggested:

1. Understand that your increased risk for early death and the altered, compromised lifestyle forced by your smoking habit is truly reversible.
2. Commit to smoking cessation and understand that repeated attempts are often necessary. Those who succeed attempt to do so, on average, four times before success is achieved.
3. Become familiar with nicotine supplemental products in all of their various forms and their respective success rates.
4. Become familiar with the additional supportive sources available to you such as the Blue HealthLine sponsored by the Fund through its affiliation with Blue Cross Blue Shield of Michigan.

Are you Ready to Quit? Here are the Facts!

Twenty percent of all deaths in the United States are tobacco related. A high percentage of all cancer deaths and all but a few percent of lung cancers are directly associated with cigarette smoking. Other cancers are clearly related to the use of tobacco products, these being mouth, tongue, bladder, esophagus and kidney cancer. A very close relationship exists between tobacco use and stroke as well as heart attack and peripheral vascular disease. Tobacco users will lose on average, 12 years of their life expectancy. Less significant, but important to those who wish to age gracefully is the fact that smoking adds approximately 10 years to the average individual's skin age appearance. In addition, it is important to recognize that those whom you hold most dear may be adversely affected by passive smoke in the form of increased rates of childhood asthma and even an occasional case of lung cancer. Lastly, tobacco smoke contains many organic chemicals that are known to be toxic such as formaldehyde, cyanide and ammonia, as well as one that everyone is familiar with the effects of — carbon monoxide.

Benefits of Cessation

Within weeks of cessation, your lung function ceases to deteriorate at the accelerated rate induced by the habit and within a few months, improvement can be documented by volumetric respiratory tests. Your chronic lung disease will now progress at a much slower pace, not only allowing you to live but with a much improved quality of life. Your cardiac risk, particularly that of heart attack, returns to normal most quickly of all. There is a significant improvement in as early as a month and a return to normal at one year. However, stroke risk does not return to baseline until 5 years after smoking cessation.

Steps in Finally Taking Action

- Step 1: Commit to cessation no matter how many times it takes.
- Step 2: Avail yourself of counseling through your physician and other sources of information, such as those available through your Blue HealthLine at 1-800-811-1764 or TTY 1-800-240-3050 for the hearing impaired.
- Step 3: Become familiar with one of the several forms of nicotine replacement systems (see above chart reprinted, in part, from the American Cancer Society, "Set Yourself Free," 1999; prescription necessity has been reviewed and updated by Blue Cross Blue Shield of Michigan) and, if appropriate, make use of them. Please note that the cost of the non-prescription nicotine replacement alternatives are not covered by the Fund, and prescription alternatives are subject to your plan's co-payment structure.

Remember, initial failures are common. Most people fail between three and four times before they finally succeed. Good luck and good health.

From the Fund's Medical Director, Elliotte D. Moss, M.D.

Type	How Used	Dosage	Benefits	Drawbacks
Nicotine Gum (Nicorette) Prescription not needed.	Chew briefly, then "park" in the mouth. Nicotine absorbed through the mouth lining.	Begin with 2 or 4 mg. No more than 20 pieces per day. Taper dose before stopping. Use for 2-3 months (maximum 6 months).	Convenient, lots of flexibility. Delivers nicotine more quickly than the patch.	Can't eat or drink while chewing. Have the patient talk with a dentist if dental or jaw problems exist.
Nicotine Patch (Nicoderm CQ, Habitrol or Nicotrol) Prescription not needed. (Prostep) Prescription needed.	Apply to the skin every day. Releases steady dose of nicotine through the skin.	Begin with either 21 or 14 mg. Taper to 7 mg. Use for 2-3 months. Available as a 16-hr. or 24-hr. patch.	Very easy to use. Few side effects.	Releases nicotine more slowly than other systems. Can cause skin irritation and vivid dreams.
Nicotine Spray (Nicotrol NS) Prescription needed.	Every 1-2 hours, take deep breath, spray once into each nostril and exhale through the mouth.	Use for 3 months and gradually taper off.	Delivers nicotine fastest. Good at reducing sudden cravings.	Nose and sinus irritation common at first but usually subside. Not indicated with allergies, asthma.
Nicotine Inhaler (Nicotrol inhaler) Prescription needed.	Inhale nicotine by bringing the inhaler to the mouth when an urge hits.	At least 6 cartridges per day for the first 3-6 weeks, then taper off. Use for 3 months.	Delivers nicotine as quickly as gum; "comfort" of hand to mouth; few side effects.	May cause mouth or throat irritation. Not for patients with asthma or chronic lung disease.
Bupropion Hydrochloride (Zyban) Prescription needed.	Take one pill per day for the first three days; then take one pill in the morning and one in the late afternoon.	Start two weeks before quitting; after quitting, continue 7-12 weeks.	Easy to use; few side effects. May be more helpful when used with the patch.	Do not use with seizure/eating disorders, Wellbutrin, MAO inhibitors, during pregnancy or if breast-feeding.

Automobile Related Injury/Illness Benefit Exclusion

Due to the increasing number of Fund participants residing in states other than Michigan, the Fund has reviewed its rules concerning exclusions and limitations for automobile related injury and illness and has determined that they are in need of clarification. The Summary Plan Description states:



- Based upon Michigan's "No-Fault" automobile insurance laws providing for comprehensive health care benefits to any person(s) suffering an injury or illness as a result of an automobile accident in Michigan, or to participants and their dependents who are covered under Michigan "No-Fault" automobile insurance and suffer an injury or illness in an out-of-state automobile-related accident, NO medical benefits will be paid by the Plan for auto-related injuries or illnesses.
- Plan participants and their eligible dependents residing outside the State of Michigan who suffer an injury or illness resulting from an automobile accident out-of-state will NOT be eligible for any medical benefits under any Welfare Fund Plan, if such benefits are payable or required to be covered under other insurance or applicable state law.

This means that, if a participant's auto-related injury or illness is not covered under Michigan's "No-Fault" automobile insurance laws, **Fund coverage will be provided in excess to any state mandated or other applicable insurance coverage up to the maximum payable under the Fund's plan of benefits.** Participants in this circumstance will be required to provide the Fund with information pertaining to other insurance and third party liability. The excess benefits provided by the Fund will be subject to the Plan's subrogation and reimbursement provisions.

Deferral of Retiree Medical Program Participation

Under the Fund's Retiree Medical Program, if you have other medical coverage when it comes time for you to retire, you may defer Fund coverage until you need it. If the Fund grants your request for deferral, your right to continued deferral will last only so long as your other medical coverage remains in effect. However, you must first remember to make timely application for enrollment in the Program and, of course, satisfy the Fund's eligibility requirements. When you decide to participate in the Program, you must meet all of the requirements then in effect.

Any below age 50 retiring participant who qualifies for a "30 and Out Pension" and who satisfies Retiree Medical Program eligibility requirements (other than having reached age 50), must request a deferral within 90 days of his retirement date to establish entitlement at age 50.

All requests to defer Retiree Medical Program coverage, must be in writing. Under age 50 deferral requests must be accompanied by documentation reflecting "30 and Out Pension" eligibility.

Prior Authorization Required for Mental Health and Substance Abuse Treatment

Personal problems can affect your job, family, social, emotional and physical well being. If you or your family member is experiencing psychological or substance abuse problems, call the Teamsters Confidential Help Line at

1-800-457-8540



for an authorization of professional services and a referral to an appropriate local mental health or substance abuse provider. All mental health and substance abuse treatment, inpatient or outpatient, must be approved in advance by the Fund. There are trained call center staff on hand 24-hours a day, seven days a week and all calls are strictly confidential.

Coordination of Benefits

If your spouse has coverage under another group health plan, that plan will be deemed primary for your spouse's coverage. It will also be deemed primary for your eligible children if your spouse's birthday is earlier in the year than yours. In such cases, the Fund, as the secondary plan, will coordinate payment of benefits with the primary plan. Please review the following illustration:

The Fund received a claim from a non-PPOM provider on behalf of an eligible dependent who had primary coverage under other insurance. The claim was for an office visit charge of \$100, lab charge of \$20, x-ray charge of \$50 and injection charge of \$10. Fund coverage was under the SOA benefit plan.

Office Visit: Office visit coverage is a Major Medical benefit which is subject to an annual deductible of \$100 and is then payable at 80% of the allowed charges. The Fund's Major Medical Allowed amount was \$100. The primary plan paid \$80. The dependent had not satisfied the \$100 deductible requirement.

Lab: Lab coverage is a Basic benefit. The Fund's Basic Allowed amount was \$15. The primary plan paid \$10.

X-Ray: X-Ray coverage is a Basic benefit. The Fund's Basic Allowed amount was \$50. The primary plan paid \$50.

Injection: Injection coverage is a Major Medical benefit. The Fund's Major Medical Allowed amount was \$10. The primary plan paid \$0.

Service	Charges	Basic Allowed	Major Med Allowed	Major Med Deductible	Major Med %	Major Med Benefit	Total Fund Benefit	Primary Plan Payment	Fund Payment
Office Visit	\$100	\$0	\$100	\$100	80%	\$0	\$0	\$80	
Lab	\$20	\$15	\$0	\$0	0%	\$0	\$15	\$10	
X-Ray	\$50	\$50	\$0	\$0	0%	\$0	\$50	\$50	
Injection	\$10	\$0	\$10	\$0	80%	\$8	\$8	\$0	
Totals	\$180		\$175				\$73	\$140	\$35

As you will note from the above description and Fund benefit analysis chart, of the \$180 in charges, \$175 was paid between the primary (the spouse's) plan and the secondary (the Fund) plan. Had there been no other plan to coordinate with, the Fund would have paid \$73 and the participant would have been responsible for the \$107 balance. Under coordination of benefits rules, to calculate the Fund's payment as the secondary plan, the Fund first calculates its Total Allowed Amount of \$175 (pursuant to its reasonable and customary fee schedule) and its Total Fund Benefit of \$73 (after subtracting deductibles and coinsurance amounts). It then calculates the difference between the Total Allowed Amount and the Primary Plan Payment (\$175 - \$140 = \$35). The Fund will pay such difference up to the Total Fund Benefit amount. In this example, therefore, the Fund would pay the full \$35 difference.

If you are sending in a claim to the Fund for secondary coverage, you must include the payment voucher from the primary carrier so that the claim can be processed correctly and promptly.

Youth Depression and Alcohol and Drug Use

According to ValueOptions, the Fund's mental health and substance abuse services provider, depression in children and adolescents is a major health problem in the United States. Unfortunately, it is often ignored or misdiagnosed. It is not uncommon for parents to attribute moodiness to hormones or other factors that are a normal part of growing up. However, major depressive disorders occur in approximately two to four percent of children, and increase two to threefold during adolescence. The list below describes signs and symptoms of depression to look for:



- **persistent sadness and increased crying**
- **loss of interest in favorite activities**
- **frequent physical complaints**
- **anxiety (separation anxiety or excessive anxiety about school performance)**
- **poor school performance and/or frequent absences**
- **boredom; unable to concentrate or sluggish**
- **irritability**
- **aggression**
- **change in eating or sleeping patterns**
- **poor peer relationships**
- **promiscuity**
- **alcohol and drug use**

Young people sometimes turn to alcohol and drugs to cope with their anxieties and problems, to feel more adult-like, to fit in, to rebel or to satisfy their curiosity. Teens with depression or other mental health problems are particularly vulnerable to alcohol and drug use. Many adolescents fail to recognize that they are depressed and why they are depressed. But, when they drink alcohol or take drugs to alleviate their stress or emotional pain, their condition can worsen. Alcohol is a drug, with serious risks and potentially harmful consequences. Other drugs may also be dangerous and even addictive. Casual use of drugs such as club drugs, inhalants and steroids can impair health and in some instances cause brain damage or death.

It is important to get help for alcohol and drug problems early, because the longer someone waits to get help, the harder it is to get better. Adolescents who use alcohol or other drugs should be screened for depression, anxiety disorders and the severity of their substance abuse problem. When appropriate, they should be referred to education or support groups, or for counseling.

If you feel your child needs professional care for depression, alcohol or drug abuse, please contact the Fund's mental health and substance abuse confidential help line at 1-800-457-8540 for crisis counseling or for referral to an appropriate network provider. Trained professionals are available 24-hours a day, seven days a week to assist you.

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Field Services Department

Meet the Fund's Field Services Department

The Fund's Field Services Department is responsible for assisting the Local Union Business Agents during contract negotiations including meeting with the negotiating committee and company representatives to explain the benefit plans.

During the year, the Field Services representatives also visit regularly with the local union offices throughout the state, meeting with Local Union officials and participants to address benefit questions, claim/service problems and other Fund related issues.

The Field Services Department provides the Fund with a crucial direct connection to the people whom it serves and thereby, with its special insight, helps shape the Fund's policies and direction.



From left to right
Sherry, Sandie, Earnestine, Elizabeth