

Michigan Conference of Teamsters Welfare Fund



Messenger



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Message from the Fund's Executive Director

Dear Teamster Families,

Springtime Greetings from Trumbull Avenue. The vernal equinox has come and gone and the summer solstice fast approaches, as we continue our annual tilt into the light of the warming sun. Despite the dreadful past year, burdened by war's devastation and divisiveness, the subtle and brutal effects of terrorism, the ruinous arrogance of our corporate and political leaders, the further hemorrhaging of America's wealth and employment opportunities and the high anxiety felt by nearly every family over our jobs, our children's prospects for the future and our own prospects for a dignified old age – despite all that, we cannot help but feel a glimmer of optimism that this year, we'll begin to turn the corner.

But for now, the battle outside rages. We are inspired by the heroic efforts made in support of the nurses at Northern Michigan Hospital of Petoskey, the extraordinary preparation and effort invested in the National Master Freight Agreement negotiations and the many hard fought negotiations and organizing campaigns throughout the state. We at the Fund are likewise fully focused on overcoming our obstacles and dedicated to providing you with the best administered, most financially secure, and most responsive welfare fund to be found anywhere.

Best wishes for a fine summer,

Richard Burker

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Protected Health Information

As we previously advised you, the HIPAA Privacy Rules which became effective April 14, 2003, have caused the Fund to modify procedures to ensure your Protected Health Information (PHI) remains confidential and secure. This includes reasonable efforts at verifying your identity when you contact us. We appreciate your patience and understanding regarding these new rules.

To remind you, the Fund cannot share your PHI with those not involved with treatment, payment or healthcare operations unless you authorize the release of that information. For example, your spouse cannot obtain information regarding your claim, or the status of your claim, without your written permission. However, the Privacy Rule does allow parents to obtain access to their dependent children's PHI when such access is not inconsistent with state law.

You can obtain an Individual Authorization to Release Protected Health Information form by contacting the Fund's Member Services Department at 313-964-2400, or by visiting the Fund's Web site at www.mctwf.org.

Flexible Dependent Coverage

The Flexible Dependent Coverage Program provides a "Medical Spending Account" of up to \$540 annually to cover certain medical, dental and optical expenses that are not reimbursed by the Fund or other group plans and that are considered deductible from individual tax returns if itemized (see list on page 2 for examples of those eligible and ineligible items).

The Fund has decided to expand the Flexible Dependent Coverage Program comprised of SOA, TIF and Key Plans only, to include the PEP and I&S Plans.

To participate in this Program, any dependents the participant may have must provide evidence of other coverage and must waive Fund dependent coverage for all medical and prescription drug benefits. Once the Flexible Dependent Coverage Election Request form is completed and approved, the waiver remains in effect until such time as the participant notifies the Fund to discontinue participation in the Program.

For those participants already enrolled in the Program, when submitting your Flexible Spending Allowance Claim Form (a copy of this form can be obtained by contacting the Fund's Member Services Department or on our website at www.mctwf.org), you must include your payment receipts.

You may ask your pharmacist to provide you with a printout of your prescription claims you received during the time period you are seeking reimbursement of your co-payments. This will cut down on the amount of receipts you need to keep track of.

Generally, eligible expenses include your medical, dental and optical expenses that are not reimbursed by other group plans and that you could deduct from your individual tax return if you itemized your deductions, as described in IRS Publication 502. They are as follows:

Eligible Items

- abortion;
- acupuncture;
- alcoholism treatment;
- ambulance service;
- artificial limbs;
- artificial teeth;
- birth control pills;
- Braille books and magazines;
- breast reconstruction surgery following mastectomy;
- capital expenses for home medical equipment or improvements for medical care;
- car controls and equipment for disabled persons;
- chiropractic care;
- Christian Science Practitioner;
- contact lenses;
- co-payments and deductibles paid under this and other benefit plans;
- crutches;
- dental treatment;
- diagnostic tests;
- disabled dependent care;
- doctors' fees;
- drug addiction inpatient treatment;
- drugs requiring a prescription;
- duplicate prosthetic devices;
- eye surgery;
- eyeglasses;
- fertility enhancement;
- guide dogs;
- health institute treatment prescribed by a physician;
- hearing aids and exams;
- hearing treatment;
- hospital services;
- injections;
- insulin;
- in vitro fertilization;
- lab fees;
- lead based paint removal, when child has lead poisoning;
- learning disability tuition;
- legal fees necessary to authorize treatment for mental illness;
- legal fees associated with procuring an egg donor for the direct purpose of correcting infertility;
- lifetime care - advance payments ensuring lifetime care in a retirement home, medical portion;
- lodging in hospital or similar institution while receiving care;
- long-term care premiums and unreimbursed expenses;
- meals at hospital or similar institution while receiving inpatient care;
- medical conferences for chronic illness of you, your spouse or dependent: admission & transportation;
- medical equipment, supplies, or diagnostic devices to the extent that such items mitigate the effect of an injury or illness or assist in the treatment of the injury or illness (with or without a prescription);
- medical services;
- medicines prescribed by a physician;
- mentally retarded, special home for;
- mouth guards prescribed by your doctor;
- nursing home services (medically necessary);
- nursing services;
- operations – medical expenses you pay for operations that are not unnecessary cosmetic surgery;
- optometrist fees;
- organ transplants;
- orthodontic treatment;
- orthopedic shoes;



- osteopath;
- oxygen;
- periodontal fees;
- prosthesis;
- psychiatric care;
- psychoanalysis;
- psychologist;
- psychotherapy (by approved provider);
- special schools for the handicapped;
- sterilization;
- stop-smoking programs (does not include non-prescription drugs such as nicotine gum & patch);
- surgery;
- telephone for the deaf;
- television equipment for hearing impaired;
- therapy;
- transplant donor expenses;
- transportation for medical care;
- tuition – medical expenses charges for medical care included in tuition of a college/private school;
- vaccinations;
- vasectomy;
- vitamins requiring a prescription;
- vision correction surgery (such as LASIK or radial keratotomy);
- weight-loss program – if diagnosed by physician with specific disease (includes group fees; doesn't include dues for gym, health club, or spa; doesn't include diet food or beverage unless food doesn't satisfy normal nutritional needs, food alleviates or treats an illness, and need for the food is substantiated by a physician);
- wheelchairs or autoette;
- wig; and,
- x-rays.



Examples of Ineligible Items

- any expense you deduct on your individual tax return;
- babysitting, child care, nursing services for normal, healthy baby;
- controlled substances;
- cosmetic surgery (unless necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease);
- dancing/swimming lessons (even if recommended for general improvements of your health);
- diaper service;
- electrolysis/hair removal;
- expenses for trip or vacation taken for a non-medical reason;
- funeral services;
- group medical insurance premiums from the spouse's employer paid with pre-tax dollars;
- hair transplant;
- health club dues;
- household help;
- illegal operations/transplants;
- maternity clothes;
- meals and lodging away from home for medical treatment not received at a medical facility;
- medical savings account contributions or distributions;
- nursing services for a healthy baby;
- nutritional supplements not requiring a prescription;
- over-the-counter medicines and medical aids (except for insulin);
- personal use items;
- psychoanalysis you receive as a part of your training to be a psychoanalyst;
- teeth whitening procedures; and
- weight-loss programs if your doctor recommends the program for your general health or if for improving appearance or sense of well-being, or diet foods that substitute for normal food.

Prior Authorization of Medical Services

Under the Fund's medical policies, prior authorizations are required for certain procedures, services and products to allow for payment of benefits under your Plan. A letter of medical necessity must first be submitted to the Fund's Utilization Review Department by your physician for review, to consider payment of services. The Fund's procedures, services and products that require prior authorization include:



- ◆ Bariatric Surgery/Follow-up Surgery
- ◆ Bilateral Breast Reduction
- ◆ Blepharoplasty
- ◆ Cardiac Rehab
- ◆ Custom Foot Orthotics
- ◆ Dental Implantation
- ◆ Durable Medical Equipment—Purchase
- ◆ Epidural Steroid Injection for Cervical, Thoracic & Lumbar Regions
- ◆ Gastric Stapling
- ◆ Growth Hormone Stimulation Test & Professional Care Supplies (when ordered by a physician other than a pediatric endocrinologist)
- ◆ Insulin Infusion Pump (administered inpatient)
- ◆ Home Health Care
- ◆ Hospice
- ◆ Human Organ Transplants
- ◆ Insulin Infusion Pump (administered inpatient)
- ◆ Insulin Pump Therapy/Continuous Subcutaneous Insulin Infusion
- ◆ Investigational Procedures
- ◆ Mental Health & Substance Abuse
- ◆ Orthotics
- ◆ Otoplasty
- ◆ Pain Management (injections)
- ◆ PET Scans
- ◆ Sclerotherapy
- ◆ Skilled Nursing
- ◆ Sleep Studies
- ◆ Wheelchair Purchase

All questions you may have regarding this benefit policy should be directed to the Member Services Department.

Definition of Dependent Child

Effective January 1, 2004, The Fund's definition of a dependent child of a covered participant will be defined as:

A participant's unmarried natural, step, or adopted child, or one who has been placed with a participant for adoption, who –

- has not attained age 19; or
- has not attained age 24 and is a full-time student (as demonstrated by a Full-Time Student Eligibility Verification form submitted for each school grading period); provided that for post-high school studies, the student must be enrolled full-time in a degree or certification program offered by an accredited academic institution or an accredited vocational school; or
- subject to Trustee review, is determined by a licensed physician, psychologist or psychiatrist to be permanently and totally disabled by a disability while the individual was covered as a dependent (first two bullets above) by a Fund benefit plan.

Maternity Care for Dependent Daughters

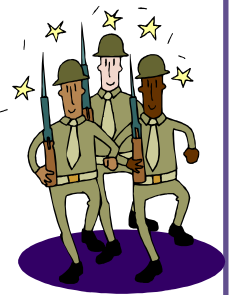


Eligible pre-natal and post natal care, obstetrical and hospital services related to maternity care, incurred on or after February 25, 2003 for eligible dependent daughters of participants will now be paid by the Fund. Such coverage will be subject to the terms and conditions of the participant's benefit plan and paid according to the Fund's in-network and out-of-network reimbursement rules.

Accordingly, as of January 1, 2004, the Fund will no longer cover a child claimed as a dependent of the participant on the participant's most recent federal tax return who does not satisfy one of the bulleted criteria above.

Military Leave Rule Reinstatement of Eligibility

Generally, the Fund requires a participant to re-establish eligibility following a 26 or more week break in service (i.e., 26 or more weeks where no contributions are made to the Fund on the participant's behalf). Further, participants who enter or are drafted into military service for more than 180 days must resume employment with a contributing employer within 90 days of discharge to reinstate coverage without having to re-establish eligibility (this deadline is extended up to two years if the participant is hospitalized or convalescing because of service related illness or injury).



The Fund has adopted the following military leave rule for all non-retired participants:

Effective immediately, the Fund has expanded the 90 day window to 26 weeks for military leave participants. Therefore, if a participant returns to covered employment within 26 weeks following military service discharge, coverage will be reinstated on the day the participant returns to work. The extension for service related hospitalization or convalescence remains the same.

Retiree Medical Program Rules

Since the July, 2001 publication of the Summary Plan Description booklet, several modifications have been made to the Retiree Medical Program eligibility rules. The following provides a complete update to those rules:

ELIGIBILITY

Retirees age 57 older -

- ◆ must have had contributions for a plan that includes the Retiree Medical Program benefit (either by an employer or appropriate self-contributions) made on his or her behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately preceding the Retirement Date (please refer to **DEFINITIONS**) 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 an employee performed seasonal work, 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 to seasonal and non-seasonal work during the measuring period);
- ◆ must be eligible for benefits based upon either company or appropriate self-contributions at the time of retirement;
- ◆ must not be eligible for Medicare coverage; and
- ◆ must not be engaged in Prohibited Employment (please refer to **DEFINITIONS**).



Retirees Under 57 -

◆ Age 50 through 56 - Retiring Prior to January 1, 2005*

☞ must meet all of the eligibility rules for age 57 or older described above, and additionally must have worked at least 20 years under Teamster collective bargaining agreements (please refer to **TEAMSTER CBA RULES**).

* **Effective January 1, 2005, a participant must be age 57 to participate in the Retiree Medical Program (with the exception of “30-and-Out Pension” retirees, which are addressed below). Retirees age 50 through 56 must defer participation to age 57 (please refer to DEFERRAL OPTIONS).**

◆ “30-and-Out Pension” Retirees Under Age 50-

☞ must meet all of the eligibility rules for age 57 or older described above, with the exception that the Retirement Date is established based only on employer contributions (not COBRA contributions – please refer to **COBRA CONTRIBUTIONS**) and additionally the Retiree must qualify for a “30-and-Out Pension” from a Teamster Pension Fund. Coverage in such case is deferred until the Retiree attains age 50 (please refer to **DEFERRAL OPTIONS**), contingent upon receipt of a written request from the Retiree and documentation of the “30-and-Out Pension” from a Teamster Pension Fund.

ELECTION & SELF-CONTRIBUTIONS

- ◆ The Retiree must elect to receive Retiree Medical Program coverage by filing with the Fund the Retiree Medical Program Application form within 90 days immediately following the Retirement Date. In the case of retirees who have deferred coverage, coverage will commence as of the first of the following month following the election and receipt of the first contribution on or before the 20th of the preceding month.
- ◆ The Retiree must make self-contributions to the Fund in the amount established by the Trustees, the first of which must be submitted to the Fund with a copy of the Fund’s letter of acceptance, by the date indicated in the letter, and thereafter must be received on or before the 20th day of the month preceding the month for which coverage is provided. Self-contribution rates are determined by years of Fund service and age at the time of commencement of coverage.

UNIFORMED SERVICES (MILITARY LEAVE) CREDIT

Uniformed Services Credit may count toward satisfying Fund participation requirements (i.e., years of service) for establishing Retiree Medical Program eligibility under the 5 out of 5 or 7 out of 10 year contribution rule (more fully described under **ELIGIBILITY**) and toward determining the Retiree Medical 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 the Fund “contributing employer” on his behalf for a benefit plan that included retiree benefits;
- ◆ 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”);
- ◆ The participant applied for return to work with a contributing employer within the following time frames:
 - ☞ Within 90 days after completed duty time of more than 180 days.
 - ☞ Within 30 days after completed duty time of 31 to 180 days.
 - ☞ 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 the Fund;
- ◆ 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 the Fund.

Retirement Date is defined as the date a participant ceases to be covered by the Fund 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 (please refer to **COBRA CONTRIBUTIONS**).

COBRA CONTRIBUTIONS



- ◆ **Age 50 or Older Retiring Participants** - may choose to make COBRA contributions to add to their years of Fund service and/or age (which will allow them to participate in the Retiree Medical Program at a lower self-contribution rate).
- ◆ **Under Age 50 Retiring Participants** - may not count COBRA contributions toward establishing their Retirement Date.

EXAMPLE: If a participant is 48 years of age and leaves covered employment with 29 years of pension service credit, that date, extended by remaining benefit bank weeks, will be his Retirement Date. The fact that he thereafter purchases one more year to establish eligibility for a “30-and-Out Pension” and pays COBRA contributions during that one year period will not entitle him to eligibility at age 50 to the Retiree Medical Program.

DEFERRAL OPTIONS

◆ **“30-and-Out Pension” Under Age 50**

Participants who otherwise qualify for Retiree Medical Program coverage, with the exception of the age 50 requirement, but who qualify for a “30-and-Out Pension” from a Teamster Pension Fund, may defer coverage until age 50 or older by written request and submission of documentation of the “30-and-Out Pension” eligibility. At such time as the deferring Retiree elects to participate in the Retiree Medical Program, the self-contribution rate will be calculated at the age the Retiree commences coverage.

◆ **Age 50 and Older**

Pre-Election - Retirees who are otherwise eligible for Retiree Medical Program coverage may defer election of that coverage upon written request. At such time as the deferring Retiree elects to participate in the Retiree Medical Program, the self-contribution rate will be calculated at the age the Retiree commences coverage.

Post-Election

Retirees may defer coverage any number of times after election and commencement of participation in the Retiree Medical Program, upon written request, subject to the requirement that the Retiree must defer coverage for no less than 12 months each time. At such time as the deferring Retiree re-elects to participate in the Retiree Medical Program, the self-contribution rate will be the same rate fixed for the Retiree at the time of deferral (see Exceptions, below).

Post-Election Exceptions/Considerations

- ☞ If the deferral is for the purpose of employment as a bargaining unit member by an employer that contributes to the Fund for a plan that includes retiree benefits, the 12 month minimum deferral period will be waived.
- ☞ 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 the Fund). Therefore, the deferring Retiree may continue coverage under the Retiree Medical Program by making his monthly self-contribution until eligibility for the new coverage is established.
- ☞ If by virtue of active Fund participation during the deferral period, the re-electing Retiree can newly satisfy the initial eligibility rule of 5 out of 5 or 7 out of 10 years of Fund participation immediately preceding re-election, the self-contribution rate will be recalculated to reflect the additional year(s) of service earned and the age of the Retiree at the time of re-election.

TEAMSTER CBA RULE

In determining whether a Retiree satisfies the requirement to have worked at least 20 years under Teamster Collective Bargaining Agreements, the following periods shall be considered:

- ◆ each 52-week period during which he worked under a Teamster Collective Bargaining Agreement (i.e., as a Teamster bargaining unit member);
- ◆ each 52-week period during which the Fund or Local Union made contributions to the Fund on his behalf;
- ◆ each 52-week period during his employment as a non-Teamster bargaining unit member that his employer also employed Teamster bargaining unit members; and
- ◆ each 52-week period during which military leave occurred and was credited in accordance with the **UNIFORMED SERVICES CREDIT** rule in conjunction with one of the above described periods.

Childhood and Adolescent Immunization Schedule 2003

Every year the Center 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 2003 Childhood and Adolescent Immunization Schedule which lists each vaccine under the routinely recommended ages. As stated under the Fund's Wellness Program, all co-payments and deductibles are waived.

Vaccine	Range of Recommended Ages			Range of Recommended Ages					Preadolescent assessment			
	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs.	13-18 yrs
Hepatitis B (1)	Hep B #1	only if mother HBsAg										
		Hep B #2		Hep B#3				Hep B series				
Diphtheria, Tetanus, Pertussis (2)		DTaP	DTaP	DtaP		DTaP			DTaP	Td		
Haemophilus Influenzae Type b (3)		Hib	Hib	Hib	Hib							
Inactivated Polio		IPV	IPV	IPV					IPV			
Measles, Mumps, Rubella (4)					MMR #1				MMR #2	MMR		
Varicella (5)					Varicella			Varicella				
Pneumococcal (6)		PCV	PCV	PCV	PCV				PCV	PPV		
..... Vaccines below this line are for selected populations										Hepatitis A series		
Hepatitis A (7)												
Influenza (8)					Influenza (annually)							

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2002, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

1. Hepatitis B vaccine (HepB). All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months. These infants should be tested for HBsAg and anti-HBs at 9-15 months of age.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months.

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. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. Haemophilus influenzae type b (Hib) conjugate vaccine. 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. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

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 that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

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 two doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups.

7. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions, and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart.

8. Influenza vaccine. Influenza vaccine is recommended annually for children age ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes, and household members of persons in groups at high risk; and can be administered to all others wishing to obtain immunity. In addition, healthy children age 6-23 months are encouraged to receive influenza vaccine if feasible because children in this age group are at substantially increased risk for influenza-related hospitalizations. Children aged ≤12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.



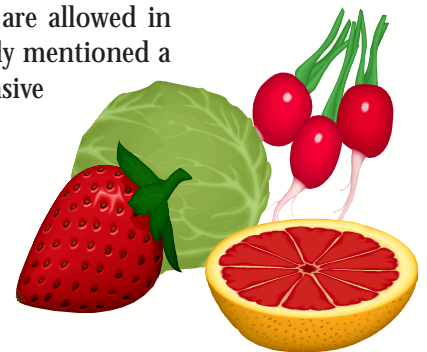
An Old Way of Eating For Our Modern Style of Life

May I suggest to you a diet program likely to succeed! One in which the rules are very simple and therefore easy to apply. This program made popular by Dr. Dean Ornish is entitled "His Life Choice Program for Safe Weight Loss While Eating Abundantly." Dr. Ornish has used this program in his quest to treat cardiac patients having significant disease symptoms, rather than choosing a surgical approach. Dr. Ornish noted some very interesting results in patients taking this dietary approach; a more energetic, less obese, less irritable and excitable individual with a more generally satisfied sense of life's experience. He also observed sustained weight losses in excess of five years, reduction in blood sugar in type II diabetics, a remarkable decrease in cholesterol, and most surprising to him a large decrease in the visualized coronary obstructions (after one year of remaining on the diet) viewed by an angiography.

So what is the secret? It is no more that a modern version of the foods which Asians, Indians, and Africans have eaten, until they were recently overcome by western civilization and incidentally, western degenerative disease. Most Americans also ate this way at the turn of the last century when vascular diseases were a curiosity and life was only limited by diseases we have since conquered. This diet is a vegetarian low-fat diet with whole grain breads and cereals, a moderate intake of fruits, beans, legumes as a source of protein, and a moderate energy source of non-refined complex carbohydrates to sustain us between meals. Refined white flour and rapidly absorbed small sugars are highly limited, as they stimulate insulin release, which causes fat storage and increased hunger.

This diet is simple in concept and is based on several sound principles. High fat intake leads to fat storage and thus fat people. Highly refined sugars (sweets) lead to insulin release, which causes increased hunger by reducing blood sugar quickly and also increasing fat storage (insulin makes fat). Complex carbohydrates (whole wheat, potato, etc.) take hours to digest and stimulate less insulin release and thus, are used for energy and are not as easily stored as fat. These high fiber carbohydrates allow twice the volume of food intake with half the amount of calories. Each gram of carbohydrate stores only four calories and therefore only requires four calories to be utilized for consumption, while each gram of fat requires slightly more than double the calories at nine calories per gram. Protein, incidentally, also stores and utilizes only 4 calories per gram, but like the typical peanut, is frequently packaged by nature with an unacceptable amount of fat. It is difficult to eat a high-protein diet without also getting too much simultaneous fat. In addition, some questions exist on the safety of a high protein diet in relationship to kidney function. There is no civilization in history that has demonstrated a safe intake of a high protein diet for a continued period of time. Certainly, the competitive diets currently offered suggest high quantities of protein in the form of animal products with an equal amount of fat, but they are currently being tested for their safety at some large prestigious universities. The results of that research have not yet been reported, and in my opinion, it will be some time before we can safely point to those diets as life sustaining (i.e. Dr. Atkins diet).

So, what foods are you allowed on this diet? Well, all sorts of pasta dishes, various forms of vegetarian preparations with and without pasta and/or various types of interesting and very tasty sauces. Potatoes are included (if not fried) and are prepared in all sorts of interesting ways. Breads and cereals of the appropriate type are quality sources of breakfast foods and are added in as supplements to the rest of the meals. Almost all fruits are allowed in reasonable amounts, along with non-fat dairy and low-fat yogurt products. I have only mentioned a rather limited list of the available foods presented here as part of Dr. Ornish's extensive pantry. Too many possibilities are available to include within the limited borders of this article, but a more complete discussion of the diet along with terrific recipes can be obtained by visiting www.ornish.com. Also check out Dr. Ornish's number one best seller [Eat More, Weigh Less](#), available in most book stores.



The Best of Health,

Elliott D. Moss, M.D., Fund Medical Director

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TEAMSTERS WELFARE FUND**

**2700 TRUMBULL AVE.
DETROIT, MICHIGAN 48216
313-964-2400**

*Metro Detroit 1-800-572-7687
Upstate 1-800-824-3158
Out-of-State 1-800-334-9738*




MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

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Adult Immunizations

The Fund has eliminated the Plan exclusion for adult immunizations when performed by an out-of-network provider. Effective April 28, 2003, covered immunizations provided by an in-network provider (those recommended by the Centers for Disease Control and Prevention) shall be covered out-of-network as well. Coverage for services are subject to the applicable Plan provisions and out-of-network deductibles/coinsurance requirements. The following table provides a summary of current age-based recommendations for immunizations. For a detailed statement including the Center for Disease Control's risk based recommendations, please refer to <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5140a5.htm>.

Vaccine 	14 - 49 Years	50 - 64 Years	65 Years and Older
Tetanus Diphtheria (Td)	1 dose booster every 10 years		
Influenza	1 dose annually for persons with medical or occupational indications or household contacts of persons with indications	1 annual dose	
Pneumococcal (Polysaccharide)	1 dose with medical or other indications (1 dose revaccination for immunosuppressive conditions)		1 dose for unvaccinated persons 1 dose revaccination
Hepatitis B	3 doses (1, 1-2, 4-6 months) for persons with medical, occupational, behavioral, or other indications		
Hepatitis A	2 doses (0, 6-12 months) for persons with medical, behavioral, occupational, or other indications		
Measles, Mumps, Rubella (MMR)	1 dose if measles, mumps or rubella history is unreliable; 2 doses for persons with occupational or other indications		
Varicella	2 doses (0,4-8 weeks) for persons who are susceptible		
Meningococcal (Polysaccharide)	1 dose for persons with medical or other conditions		