Michigan Conference of Teamsters Welfare Fund

Messenger

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SUMMER 2001

Message from the Fund's Executive Director, Richard Burker

I bring you excessively warm summertime greetings from the Fund's Trustees and staff. We hope this issue of the *Messenger* finds you with your boots off and a cold drink in your hands, in the midst of a great and well-deserved vacation. More importantly, we wish you and yours the best of health and good fortune.

By now you will have received our long promised **Wellness Program** booklet, researched and thoughtfully written by the Fund's long time, excellent Medical Director, Dr. Elliotte Moss, and well edited and cleverly designed by the *Messenger's* talented managing editor, Cory Buchanan. Please take the time to browse through it and heed Dr. Moss' counsel; wellness exams performed by in-network physicians are free and can save lives – please take control over your health.

In furtherance of the Fund's dedication to the principle of proactive, progressive health care delivery, we shortly will be implementing our new **Disease Management Services Program**. Disease management is a highly effective method for significantly reducing acute medical incidents and otherwise greatly enhancing the quality of life. The diseases that will be addressed by this voluntary program are asthma, diabetes, congestive heart disease and coronary artery disease. Please read about this program on page 5.

This issue of the *Messenger* provides important information about your plan of benefits. It describes benefit changes including additions to covered **human organ transplants**, clarification of the **dependent child** definition, a new **Retiree Death Benefit Program** and a very necessary capping of covered **dental benefits** at $2,500 per individual per year commencing in 2002. It also describes an **air ambulance service** rule change and rule clarifications for **death benefit beneficiary designations** and determination of **participant receipt of documents** mailed by the Fund.

Inside this issue:

Also, after careful and considerable deliberation, the Trustees determined that they must address the heavily subsidized **Retiree Medical Program**. They have determined that the $50 monthly contribution, unchanged since 1989, covering both retiree and spouse, must be increased to somewhat ease the subsidy burden on active employee rates. In a nutshell, monthly contributions for retirees with retirement dates on or before December 31, 2001 will be increased to $100 and monthly contributions for new retirees thereafter will range from $100 to $340, based on retirement age and years of Fund participation. These new rates remain far below actual retiree benefit expense.

Also included in this issue is Dr. Moss' final installment in his highly informative **Cholesterol Health Series** (we're all looking forward to Dr. Moss' next series) and a long awaited photograph of the Fund staff who service you when you call or visit the Fund, our excellent **Member Services Department**.

Of final and most heartfelt note, I sadly mark the passing of Sharon McDougall, the much loved, extraordinary and inspiring wife of Fund Trustee, Howard McDougall. The Fund staff wishes to again express its most sincere condolences to Mr. McDougall and his lovely family.

The Fund Continues to Grow !!

We welcome to the Fund approximately 1,500 new participants and families, brought in this year by Locals 7, 51, 164, 247, 283, 299, 332, 337, 339, 406, 486, 580 and 614. We wish you the very best and pledge to you our commitment to excellent service.

Non-Access Benefit

In the Fall 2000 *Messenger*, the Non-Access Benefit was announced for all active participants who did not have access to network primary care physicians, network general dentists and network orthodontists. While we encourage you and your family to apply for this benefit **prior** to services being rendered by notifying the Fund of your primary care physician, dentist or orthodontist, **we will accept applications received up to 60 days following the date services are rendered. However, thereafter, the claim will be deemed as out-of-network and all applicable co-payments and deductibles will apply.**

Death Benefit — Naming Your Beneficiary

For those Plans that provide a death benefit, participants must designate a beneficiary or beneficiaries and specify the amount each should receive.

Under Federal law, the Fund is required to strictly follow the participant's beneficiary designation (i.e. on the Fund's Enrollment Card), even if such beneficiary designation is no longer intended at the time of the particiant's death. For example, this often arises where the participant has failed to update the designation following divorce. Therefore, it is very important that participants consider their beneficiary designation whenever there is a change in family status. These changes include, but are not limited to, marriage, divorce, birth, adoption, and death of a beneficiary.

In the event of a family status change, participants should complete and file with the Fund office a new enrollment card, along with supporting legal documentation such as a copy of the marriage certificate, divorce decree, death certificate, etc.

Human Organ Transplant Additions

The Fund is pleased to announce five additional covered transplant procedures for those plans that provide the Human Organ Transplant Benefit. The chart below describes the additional procedures and their benefit maximums:

Organ	Surgical Benefits	Annual Follow-up	Lifetime Follow-up
Partial Liver	$175,000	$25,000	$100,000
Lobar Lung	$200,000	$25,000	$100,000
Pancreas/Kidney	$125,000	$25,000	$100,000
Small Intestine	$250,000	$25,000	$100,000
Small Intestine/Liver	$250,000	$25,000	$100,000

All organ transplants require prior authorization by your physician with the Human Organ Transplant Procedures Administrator at (800) 242-3504. Coverage is available only if all other eligibility provisions are satisfied.

Definition of a Dependent Child

Federal law now requires group health plans to provide coverage to children placed for adoption. In conformance with that requirement and to also clarify the definition of a full-time student, the following applies to all plans:

A dependent child of a covered participant means an unmarried child of a participant by birth, marriage, or adoption or an unmarried child who has been placed with a participant for adoption, or an unmarried individual claimed as a dependent of the participant on the participant's most recent federal income tax return who

- has not attained age 19;
- has not attained age 24 and is a full-time student (as demonstrated by a Student Verification Form that must be submitted to the Fund 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 vocational school; or
- is determined by a licensed physician, psychologist or psychiatrist to be permanently and totally disabled by a disability that commenced while the individual was covered as a dependent (see 1st and 2nd bullets, above) by a benefit plan offered by the Fund.

New Guidelines on Cholesterol Management

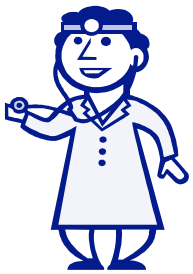
From the Fund's Medical Director, Elliotte Moss, M.D.

Following the publication of the Spring 2001 *Messenger*, the National Institutes of Health provided new guidelines for treatment of high cholesterol levels. Although a little more cumbersome in usage, these new guidelines are better directed at those of us who have the highest risk of adverse events. Consequently, the most significant benefit from treatment is directed at those who most need it.

Two new concepts have emerged. The first relates to the excess risk not previously noted in patients with diabetes, stroke, and peripheral vascular disease. These patients belong in the same category as individuals with previous heart attacks or known coronary artery disease (angina, previous heart attack, etc.). The second concept is that data exists which allows your physician to stratify your particular risk of vascular events (heart attacks, etc.). Patients not belonging to the highest risk categories initially mentioned can be further subdivided as high, medium or low risk. By taking your age, sex, blood pressure history, family history of vascular disease and so on, plotting these against graphs derived from the Framingham Research Studies, your particular need for treatment based on benefit can be determined.

Example: Those with elevated cholesterol levels, but without significant additional risk factors, may be found to have less than a 5% - 10% risk of a cardiac event in the next ten years. This is considered low risk and allows for non-medicated life style measures including exercise, diet and weight reduction. In the past, medication might have been introduced initially based on the LDL numbers alone. Today we are given the luxury of safely waiting to determine if less aggressive measures are successful. On the other hand, those with multiple risk factors, plotted against the Framingham data and found to have greater than a 20% risk of events in the ensuing ten years should be aggressively managed with medication at the inception, as their benefit for risk reduction is quite substantial.

The only aspect of these guidelines that, in my opinion, is suspect relates to the fact that in the highest risk category with LDL cholesterols between 100 and 130 mg/dl, the directives allow non-medical management for an unspecified period of time. This period of time is particularly significant as the medications we have mentioned in the past, commonly known as statins, have additional therapeutic benefits not strictly related to the reduction of LDL cholesterol. These benefits, aside from just lowering cholesterol, may include the quieting of unstable, irritated, inflamed plaque lesions that have the potential to develop into sources of clots and subsequent events. Because of this, the only alteration that I would suggest is that those in the highest of risk categories not wait for lifestyle measures but begin statin therapy immediately. I believe that the cost versus benefit and the risk versus effectiveness of these very important medications overrides dollar issues.



Do not forget to have your wellness exam. The best of health.

Retiree Plan Programs

Retiree Death Benefit Program

In July, 2001 a mailing was sent to all Fund retirees and their spouses announcing and describing the Fund's new Retiree Death Benefit Program, designed to help defray burial related expenses. The Program provides $1,000 to $5,000 in death benefits and guarantees issuance to qualified applicants regardless of their medical condition. All self-payments are payable quarterly and are based on the applicants age at the time of enrollment in the Program. The initial open enrollment period commenced July 1, 2001 and lasts through December 31, 2001. If you would like further information or would like to apply, please contact your local union or retiree club office for a description and application, or call the Fund's Member Services Department.

Retiree Medical Program Rates

The Retirement Date is defined as *the date an individual ceases to be covered by the Fund as an active employee as a result of retirement.* That date has now become a more significant consideration for your retirement planning because it may affect your Retiree Medical Program contribution rate. Therefore, we believe it worthwhile to review the rules with you regarding Retirement Date determination.

Employer contributions on your behalf for periods beyond your last date of active employment, such as for unused vacation, sick/personal time, etc., will extend your retirement date. Unused Benefit Bank Weeks and appropriate COBRA self-contributions following cessation of active employment, will also extend your Retirement Date. All such extensions to your Retirement Date will be counted toward increasing your age and years of participation in the Fund, both of which elements determine your Retiree Medical Program contribution rate.

Effective January 1, 2002 the following self contribution rates and rules will apply for participation in the Retiree Medical Program:

1. For those who retire on or before December 31, 2001 the monthly rate will be $100.
2. For those who retire on or after January 1, 2002, the monthly rate will be fixed based on their age and years of Fund participation at the time of their retirement (i.e. on their Retirement Date). The most favorable rate of $100 per month will be for those retirees with 30 or more years of Fund participation and who are aged 60 or greater. The rates increase for lower participation and lower age. The chart below reflects the new self-contribution rates. The appropriate rate is found in the cell in which the Retiree Age and Years in Fund brackets intersect.

Retiree Medical Program
Effective January 1, 2002

Monthly Self-Contribution Rate Covering Both Retiree and Spouse

For Participants Retiring on or after January 1, 2002

Retiree Age	Years in Fund 5 - 9	Years in Fund 10 - 14	Years in Fund 15 - 19	Years in Fund 20 - 24	Years in Fund 25 - 29	Years in Fund 30 +
50 - 54	$340.00	$300.00	$260.00	$220.00	$180.00	$140.00
55 - 59	$240.00	$215.00	$190.00	$170.00	$145.00	$120.00
60 - 64	$140.00	$130.00	$125.00	$115.00	$110.00	$100.00

For All Current Retirees or Participants Retiring on or before December 31, 2001
$100.00

However, the Fund will utilize the last date of active employment, when such date is on or before December 31, 2001, for the purpose of determining entitlement to the $100 monthly contribution rate. Participation in the Retiree Medical Program, nonetheless, will commence for such retirees following their Retirement Date as defined above. For example, you decide to retire by leaving active employment on December 28, 2001 and as of that date you satisfy all eligibility requirements to participate in the Retiree Medical Program. You are owed two weeks vacation for which your employer contributes to the Fund through January 12, 2002 and you have eight remaining Benefit Bank Weeks, which further extends your coverage, resulting in your Retirement Date of March 10, 2002. Due to your cessation of active employment on December 28, 2001, you will be entitled to participate in the Retiree Medical Program at the $100 monthly contribution rate commencing on your Retirement Date of March 10, 2002, following the termination of your active Fund coverage.

CareEnhance Disease Management Services

After careful consideration, the Fund has selected one of the country's leaders in comprehensive care management, McKesson, to provide to all participants who are living with or who have been recently diagnosed with asthma, diabetes, congestive heart failure and/or coronary artery disease, an important new program called CareEnhance Disease Management Services. This free, confidential, voluntary program can have a significant quality of life impact on participants living with one or more of these conditions through a thoroughly tested program of education and one-on-one nurse counseling.

Specifically, you have access to specially trained registered nurses who provide personalized education and who will tailor a plan that includes scheduled callbacks, educational mailings and a daily planner. You will be provided with a toll-free phone number that you can call anytime with questions or concerns.

With the CareEnhance asthma, diabetes, and heart programs, you have access to information that includes for example: new types of asthma and diabetes medications, vaccines that can minimize risks for respiratory infection, how to detect the early signs of an asthma attack, new delivery devices for inhaled steroid medications, increased flexibility in meal planning, new advances in caring for a heart condition and treating low blood sugar more effectively.

The CareEnhance Coronary Artery Disease Risk Factor Reduction Program is designed for individuals who are at risk for high blood pressure, high cholesterol, family history of heart problems, and for those who smoke or could benefit from exercise and nutrition advice. Coronary artery disease (hardening of the arteries) affects many individuals, but it can be prevented or managed–and this personalized program is, we believe, an excellent way to start.

CareEnhance Disease Management Services will not replace your doctor's care; rather it is to help you stay healthy between doctor visits. While your nurse will provide support, education and counseling for your condition(s), she will also routinely inform your doctor about the progress you are making with your health.

Soon, you may be receiving information in the mail regarding this new service. Be sure to read through the material carefully to see if you can take advantage of the many benefits that CareEnhance has to offer. You may also contact CareEnhance Disease Management Services directly at 1-866-221-6507 (toll-free).

It's all free and confidential, providing you with the tools to help you make good health decisions.

Receipt of Fund Documents

In resolving any dispute over whether a document mailed by the Fund was received by the participant, the Trustees will apply the presumption that the document was received based upon the following criteria, that it –

- was sent by first class mail (or by second or third class mail with return and forwarding postage guaranteed and address correction requested);
- bears the correct postage; and
- was addressed to the participant's most recent address on file at the Fund office and was not returned to the Fund as undeliverable.

To overcome this presumption, a participant must provide evidence satisfactory to the Trustees that the document was not correctly mailed or was not received.

Ambulance Services

If your medical plan covers ambulance services for ground, air, or water, these services are covered when transport is deemed by the Fund to be medically necessary. This would be so when transport by any other means would endanger the patient's health or the injury requires immediate first aid to stabilize the patient before transport to a hospital.

Please be aware that air ambulance services are payable only when all of the following criteria are met:

- the use of an air ambulance is deemed medically necessary by the Fund and ordered by a physician;
- no other means of transport is available, or the patient's condition requires transportation by air rather than ground or water ambulance;
- the patient is transported to the nearest medical facility capable of treating the patient's condition; and
- the provider is a licensed air ambulance service; not a commercial air carrier.

Dental Benefit

Participant utilization of the Delta Dental Network has been far in excess of historical utilization by similar groups, particularly for restorative treatments such as crowns, dentures and bridges, which are at nearly three times benchmark experience. After careful review and consideration, the Trustees have determined it necessary to place an annual maximum of $2,500 per person per calendar year on dental benefits for those participating in the Dental Plan or Dental & Optical Plan I. This benefit change will be effective January 1, 2002. Each calendar year (January 1st through December 31st) thereafter, your $2,500 per person annual maximum will renew.

Despite the new annual maximum, Delta Dental advises us that our dental plan remains a very rich one; well within the top 1% of all Delta Dental groups in Michigan.

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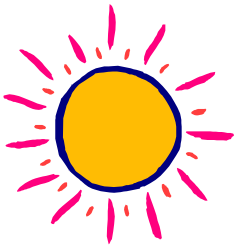
Tips From The Fund's Member Services Department



Have a Safe and Healthy Summer!!

(Top Row) Julie, Christy, Brandi, Norrice, Lisa, Fran, Kelly, Lil, Claudia
(Bottom Row) Ronda, Judy, Michelle, Cindy

As the Fund's Member Services Representatives, we are here to help you with questions regarding your benefits, eligibility, claim issues, or any other Fund related health care concerns you may have. We are available to assist you Monday through Friday from 8:30 a.m. to 5:00 p.m. However, because Mondays are the highest call volume days, if you can wait we suggest contacting us Tuesday through Friday for quicker service.

In order to answer your questions quickly and efficiently, please have handy the participant's social security number. If you are checking on the status of a claim, be sure to have the –

- patient's name
- date of service
- place of service (name of facility)
- provider of service (physician's name)

If you would like to avoid unexpected out-of-pocket costs, check with your dental or medical care provider when scheduling an appointment to verify that they are a Delta Premier dentist or PPOM physician.