Michigan Conference of Teamsters Welfare Fund

Messenger

Summer

VOLUME 21, ISSUE 3

SUMMER 2003

Message from the Fund's Executive Director

Dear Teamster Families,

It wasn't so much the drone of my neighbor's generator that was bothering me that Thursday night. It was that it wasn't coming from my backyard. The blackout caused me to think a lot about what I gamble on and what I take for granted.

I've got a friend, a tough guy, maybe 60, still playing hockey with a fury against young tough guys—skates clear of doctors, though. He took a hard check to his back—blood in his urine. Two months later he was shy one football sized tumor. Lucky thing he got hit so hard.

For the sake of the people who love you and depend on you, don't gamble on your health, don't take it for granted; please get your annual check-up.

I also urge you to take the time to read through your *Messengers*. Each issue contains information that may affect your benefit entitlement. We frequently receive appeals on benefit denials that could have been prevented had the participant acted in an informed manner. While we work hard at communicating your plan clearly and at administering it as painlessly for you as possible, it's undeniable that getting the most out of your plan requires your effort and patience as well.

The Trustees, staff and I wish you and your children happiness and good fortune for the coming months.

Richard Burker

Inside this issue:

Introducing MultiPlan

The Fund is pleased to announce that, effective on or about January 1st, 2004 it will be expanding your health care provider options by providing you access to the MultiPlan Network of practitioners and acute care and ancillary facilities. MultiPlan is one of the nation's oldest and largest health care provider networks with about 390,000 practitioners, 31,000 acute care hospitals and 50,000 ancillary facilities in all 50 states, the District of Columbia and Puerto Rico. The goal is primarily to provide network access to those who are traveling or living beyond the reach of the PPOM Network and secondarily to provide reduced out-of-pocket cost alternatives within those states where PPOM has a significant presence, but is not utilized.

How the program works:

For those of you who reside in Michigan, Ohio and Indiana, PPOM will remain your primary network while MultiPlan will serve as a complementary network. As such, MultiPlan provider reimbursements will be subject to the same deductibles and coinsurance as are presently required under your benefit plan for out-of-network usage. However, because MultiPlan has negotiated large discounts with each provider, not only will you have no balance billing exposure, but your coinsurance payment will be significantly smaller as well.

For those of you who reside in states other than Michigan, Ohio and Indiana, MultiPlan Network will be your primary network with benefits provided at in-network levels.

New Fund I.D. cards will be issued which will bear the network logos, billing instructions and phone numbers for provider listings for PPOM, MultiPlan, Delta Dental and ValueOptions. This will be the first time all of that useful information for participants and providers will be available on an identification card. The Blue Cross I.D. card will continue to be presented by participants to all pharmacists and all acute care facilities that participate in a Blue Cross plan. MultiPlan providers, arranged geographically and by specialty, will be easily accessible through the Fund's website at www.mctwf.org, which will link to the MultiPlan site.

More information will be provided in future *Messenger* issues.

Fund Death Benefit Clarifications and Limitations

Suicide Exclusion

The Fund's Summary Plan Description, for each plan that provides death benefits states, "If you die from natural or accidental causes while you are eligible for benefits, your beneficiary is entitled to a benefit in the amount shown in your Schedule of Benefits."

This is to clarify that a suicide is not deemed a natural or accidental cause under your plan and therefore, is excluded from coverage.

Gap Period Death

This is to clarify the Fund's rule regarding eligibility for death benefits in the case when an eligible participant finishes work for one work week and dies during the following work week in the gap period prior to his scheduled return to work.

The circumstance that this clarification addresses is as follows: A participant, with no available benefit bank weeks, finishes work for the work week (a work week runs from Sunday through Saturday) on Saturday (or earlier in the work week) and dies on Sunday (or later that work week) before his scheduled return to work.

The Trustees have determined that in such circumstance, a death benefit **would be payable.**

Limitation for First Year Participants

Effective August 1, 2003, the Fund will limit the amount of death benefits payable, for **deaths due to illness** of first year participants, to the level provided for in their base medical plan (i.e., SOA - $30,000; Key Plans - $20,000). Accordingly, this limitation only affects participants of Fund cafeteria plans that provide for increased death benefits. This rule does not apply if the death is accidental.

Example: A participant's eligibility commenced February 3, 2003. The participant is covered by a cafeteria plan built upon the SOA base medical plan, with an increased death benefit option of $50,000. The participant dies as the result of an illness on August 3, 2003. His death benefit will be $30,000. However, if the death had occurred on or after February 3, 2004, the death benefit would have been $50,000.

Checking Your Dental Benefits

Delta Dental, the Fund's dental provider, recently created a tool for participants to easily access important information about its dental benefits. *Subscriber Toolkit* is a secure online site that allows you the ability to:

- verify eligibility on yourself as well as your dependents;
- review up-to-date benefits information (i.e. how much of your annual benefit maximum has been used to date, how much is available to use, and the levels of coverage for specific dental services);
- access a specific claim to see what was approved and when it was paid;
- access printable ID cards and claim forms; and
- review oral health information.

To access *Subscriber Toolkit,* log on to the Fund's website at www.mctwf.org under Provider Networks on the navigation bar, click on Subscriber Toolkit and follow the directions on the screen.

Weekly Accident & Sickness Benefits Clarification of Eligibility Rule

This is to clarify the Fund's rule regarding eligibility for Weekly Accident & Sickness ("loss of time") Benefits when an employee becomes disabled **prior** to having established eligibility.

In such case, once eligibility is established, the Fund will provide benefits for all eligible medical claims incurred thereafter. However, the Fund will **not** provide Weekly Accident & Sickness benefits in connection with that disability.

Weekly Accident & Sickness benefits are payable only in connection with disabilities occurring **after** eligibility is established.

Correction

An error has been found in the first printing of the July 2001 SOA/TIF/ I&S Summary Plan Description (SPD) booklet. The Weekly Accident and Sickness Benefits section under "How the Plan Pays Benefits" on page 55 states "You will receive the amount shown in your Schedule of Benefits each week for up to a maximum of 39 weeks for each period of disability." **The correct number of maximum weeks is 26.** Although the SPD booklet was in error, your Schedule of Benefits is correct.

Contacting the Fund "After Hours"

We understand that your work schedule does not always allow you to contact us during our business hours of Monday through Friday 8:30 a.m. to 5:00 p.m, so we have modified our voice messaging system. When calling the Fund after hours, you will receive a prompt to press "5" to leave a message for a return call or to request that forms be sent to you. Your request will be responded to in one business day.

Primary Care In-Office Diagnostic Testing Restrictions

In a setting of rapidly increasing expenditures, the need for cost effective as well as quality controlled medical diagnostics has led the Fund to consider, and after careful evaluation to institute, restrictions on office based diagnostic imaging.

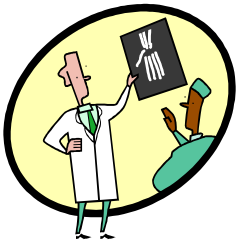
Effective January 1, 2004, the below listed diagnostic tests will no longer be covered if performed in the office of a primary care physician. Coverage will be provided only if performed in either a free standing radiologic diagnostic center or a hospital based diagnostic unit (either on, or off, a hospital campus). All PPOM primary care physicians will be notified accordingly.

- **X-Rays sinus and skull.**
- **Standard ultrasounds (i.e., abdominal, pelvic and vascular).**
- **Echocardiography and stress testing more than once annually. ***
- **Bone density testing other than to establish a base line. Follow-up is permitted once every three years. ***
- **Cardiac studies more frequently than once annually. ***

**** Prior authorization required for greater frequency.***

According to Fund Medical Director Elliotte Moss, M.D., these new restrictions will not limit the benefit, but will simply redirect it to a more appropriate setting. Dr. Moss cites the following few examples of how the restrictions might apply to common medical situations.

"It is often noted that in the process of evaluating and diagnosing a patient with acute sinusitis, a sinus x-ray is performed. The value of such an x-ray in determining the accuracy of the diagnosis and the need for treatment is well understood to be without significant contribution. In other words, it is reasonable, using a standard history and physical, to make the determination that an individual patient requires specific antibiotic therapy, for an appropriate length of time for the diagnosis of acute sinusitis without any imaging procedure being performed. If, in fact, complications ensue, whether they be related to incomplete response to treatment or mechanically contribute to recurrent, difficult to manage sinus issues, the gold standard imaging modality is a CAT scan. We, therefore, are restricting the performance of a study, which has no significant value in making a diagnosis in most patients. For those of you who, in fact, require an imaging evaluation, the CAT scan rather than the skull-sinus x-ray series, is the appropriate procedure.



Another commonly performed office-based procedure is an abdominal ultrasound. In this situation, we have no intention of casting aspersions on the quality of production or interpretation typically noted in the office setting. On the other hand, it is clear to me that having experienced the comparison of the type of equipment, quality of technical production, and validity of radiologic interpretation, the freestanding or regional hospital based radiologic center produces a finer quality product. As a result, we would like to direct our dollars in that direction. You might ask how this may impede or alter the production of information required in emergency circumstances. These circumstances typically are associated with the requirement for a sub-specialist, usually a surgeon, to evaluate the patient in tandem with the production of an ultrasound image. Therefore it seems reasonable to have both performed in the same setting typically an emergency room. Therefore, we do not feel that this restricts access to urgently required information, as it is always available in that setting and should not delay the required care also given at the hospital-based facility.

It is reasonable to cover a non-emergent bone density as a baseline study performed in a primary care setting. The reason for this is obviously that these studies are less operator dependent and more machine related, and the data generated is easily interpreted for use by the primary care physician. In addition, it is this baseline study, performed under the proper circumstance, that offers entry into specific treatment for osteoporosis. We therefore think that the initial study has an appropriate position in the primary care setting. Follow-up studies have little to do with continued application of medication and are often of little value. Nonetheless, they are typically performed at a two-to-three-year interval after the baseline and during specific medication administration. The reason that these follow ups have less value than the initial study is that once the diagnosis is made, medication is continued, regardless of the improvement noted by bone density evaluation. Even in patients who do not seem to be responding at an

Continued on Page 5

Primary Care In-Office Diagnostic Testing Restrictions (continued from page 4)

appropriate increase in bone density, studies have demonstrated that fracture reduction is significant and, therefore, this medication should be continued.

Offering cardiovascular studies in the office setting makes sense. It is clear to me that having the primary care internist or cardiologist available to observe the patient while exercising and having the video images available for comparison and interpretation is critical in the outpatient evaluation and treatment of patients with cardiac disease. We therefore have limited this series of evaluations to one in any rolling 12 month period. However, under certain circumstances, a second or third study is required, and with appropriate notification and substantiation of need, we will authorize them."

OTC Claritin and Prilosec

Several months ago, Claritin® (and Claritin-D®), the leading non-sedating antihistamine drugs became available without prescription (referred to as over-the-counter or OTC). Commencing in mid September, Prilosec®, the leading proton pump inhibitor drug, is scheduled to be sold OTC as well. Together, these two drug classes have represented approximately 10% of the Fund's prescription drug cost. As OTC drugs, they are selling for a small fraction of their branded drug costs. The drug manufacturers are intent on retaining the billions of dollars generated by these drugs and have been aggressively marketing to physicians, and directly to the public, new replacement branded drugs which provide little, if any, improvement on Claritin and Prilosec.

The Fund, like many other welfare benefit plans, has determined not to be plundered. After extensive research and consultation with its Medical Director, the Fund has decided to exclude coverage under its prescription drug program for all non-sedating antihistamines (currently those drugs are prescribed under the names Allegra®, Clarinex® and Zyrtec®) and all proton pump inhibitors (currently those drugs are prescribed under the names (Aciphex®, Nexium®, Prevacid® and Protonix®).

The exclusions will become effective November 15, 2003. However, your physician can obtain prior authorization from the Fund by establishing the medical necessity of such prescription drugs. Should prior authorization be sought, please have your physician contact the Fund's Utilization Review Coordinator at extension 490, as soon as possible, to ensure authorization prior to November 15, 2003.

Students

It's back to school time which means it's time for those eligible dependents, age 19 or above, attending a degree or certification program offered by an accredited academic institution or vocational school, to turn in their Full-Time Student Eligibility Verification Form.

You may obtain a form by calling the Fund office or by printing one from the Fund's website. To do so, go to the Fund's Home Page and click on Forms on the navigation bar.

Dependent Child Eligibility

Please also remember that, effective January 1, 2004, the Fund will no longer cover as an eligible dependent a child who is not a participant's unmarried natural, step or adopted child, or one who has been placed with the participant for adoption, subject, as always, to the plan's age limitations or disability exception.

Maximum Allowable Benefit

Please be advised that the Fund's out-of-network schedule of benefits is now referred to as a **Maximum Allowable Benefit** schedule, rather than a reasonable and customary schedule. No change has been made to the schedule itself.

Maximum Allowable Benefit is defined as *the portion of the amount billed by an out-of-network provider that has been established as the Plan's maximum payable amount, subject to deductibles, coinsurance and co-payments.*

We're on the Web!!
www.mctwf.org

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The *Messenger*, published quarterly, notifies you of changes to your plan of benefits. Please retain all issues of the *Messenger*, along with your SPD booklet and other plan materials, for future reference.

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Gathered above at the front entrance of the Fund from left to right are Trustees Bill Bernard, Ray Buratto, Bud Hillard, Bob Lawlor, Howard McDougall, and Bob Rayes.

The Fund recently completed building renovations to modernize, address new work flow requirements and to accommodate the needs of handicapped participants and retirees. These renovations include handicap ramp access, power assisted doors, an elevator and handicap accessible restrooms.

We are proud of the building's improved functionality, safety features and appearance, accomplished exclusively with union labor.

We are also proud to announce the dedication of our building to the memory of James Riddle Hoffa, whose vision and dedication to the improvement of the lives of Teamster families remains to this day the Fund's foundation, heart and inspiration.

If you are married please be sure to share this communication with your spouse.