

# Michigan Conference of Teamsters Welfare Fund



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# Messenger

## Message from the Fund's Executive Director

Dear Teamster Families:

Greetings from all of us at 2700 Trumbull Avenue. Over 2,000 of you were new to the Fund this past year. We welcome you and pledge our most sincere efforts to serve you well. However, even more so than in recent years, most of the growth was offset by layoffs and closings. 2003 saw the loss of over 1,500 participants and their families, most of whom fell victim to long eroding economic forces. Fortunately, the Fund is able to provide full coverage in the form of benefit bank weeks to ease the burden of those families. But, of course, that comes at a substantial cost to the Fund, as does the provision of immediate coverage to those new participants and their families who have been collectively bargained into the Fund.

These dynamics, as well as those with which you have been numbingly confronted, such as three consecutive years (through March 2003) of dreadful performance by the equity markets, materially escalating costs of medical care and prescription drugs and, very importantly, increasing levels of utilization, have caused a significant reduction in Fund assets. As reflected in our Summary Annual Reports, during the three year period March 31, 2000 through March 31, 2003, the Fund's net worth declined 28.5% to \$198.2 million and is projected to first stabilize at \$142.2 million in 2007, despite the benefit and rule changes that the Trustees have been compelled to enact.

While that stabilized level of net worth will allow the Fund to remain in good financial health, the reason that diminished net worth is significant to you is because fewer invested assets will result in smaller investment returns. Because investment returns subsidize contributions to fund your benefits, smaller returns require higher contributions from Employers (and from employees who are required to pay a portion of Employer contributions), as well as from COBRA participants and, inevitably, from retirees, in order to maintain benefit levels. If contribution rates rise too steeply, the financial pressure on Employers is likely to result in an Employer's demand for a more affordable plan of benefits (i.e., reduced benefits), more contribution co-pays from employees, an otherwise reduced employee economic package, or perhaps, a result far more catastrophic.

Participants and Local Union representatives have responded to the Fund's recent benefit and rule changes, particularly regarding the \$20 doctors office/emergency room co-pay and the \$250 co-pay for hospital admissions effective March 1, 2004, with two basic statements/questions paraphrased below, that I'll attempt to respond to.

**"We ratified a contract providing for a specific Fund plan of benefits. No benefit changes should affect us until contract expiration or without approval of the bargaining unit."**

*All Fund benefit plans expressly reserve to the Trustees the right to amend the plans at any time. The Trustees historically have exercised this right both to improve benefits and liberalize plan rules, when appropriate, as well as to reduce benefits and tighten rules, when necessary, to preserve the Fund's ability to provide coverage to all Fund participants and beneficiaries, regardless of when individual labor contracts expire. Such changes cannot be applied arbitrarily to one group over another.*

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**“We have bargained for these benefits. If there is insufficient funding to maintain them, why doesn’t the Fund assess a higher contribution rate on Employers rather than reducing benefits?”**

*In order to facilitate collective bargaining for Fund benefits, the Fund must set Employer contribution rates three years in advance (for example, the contribution rate for the plan year beginning April 1, 2004 was set in March 2001) even though projecting health care expenses even one year in advance is extremely difficult and imprecise. Once the Fund agrees to accept contributions from an Employer at specified rates, the Employer has a contractual right to contribute at those rates. The Fund cannot impose a higher rate. If such rates prove to be insufficient, the Fund must either reduce benefit expense or cease providing coverage. The Trustees will be setting the rate for the plan year beginning 04/01/07 shortly, but they also have determined that immediate fiscal relief is required. By acting now, those benefit changes are likely to be far less dramatic than they would be if action were delayed.*

I also want to take this opportunity to apologize to those of you who have recently waited for excessive periods to speak with a Fund member services representative. Our call volumes and the length of those calls have been abnormally high due, in large part, to the number of new and current participants seeking explanation of their benefits. We have initiated methods by which we may reduce our talk time while remaining responsive and courteous and have engaged in focused training to improve the speed of our representatives’ navigation through our new claims and eligibility systems. Through these efforts and the dedication of our member services representatives, talk time has declined and in turn, so have waiting times. We will continue to work aggressively at this until the problem is overcome.

As always, I urge you to carefully review the *Messenger* and make full use of the Fund’s Wellness Program.

Spring beckons. Best wishes on behalf of the staff and Trustees.

Richard Burker

Retiree Programs  
Retiree Programs

### Late Payments

The Trustees of the Fund have decided to accept late self-payments for participants currently covered under the Retiree Medical, Affinity Rx Drug and Death Benefit Programs, under the following condition:

- Payment for the month past due is received by the 15th of the following month, together with payment of a \$50 late fee.

Participants who have not made payment by the last business day of the month for which a payment is due will be sent a late notice reflecting the above. If the required payments are not received by the 15th of the month, coverage will be terminated, regardless of the reason (including non-receipt of the late notice).

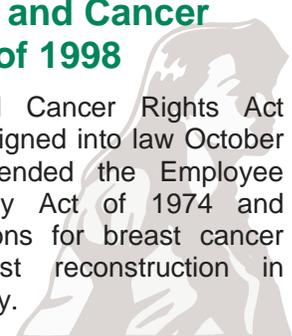
### Women’s Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act (Women’s Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women’s Health Act, group plans offering mastectomy coverage must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

The Fund has provided this coverage to you and/or your dependents, subject to Plan rules, for many years prior to this law and continues to do so.



## Know Your Disability Benefits

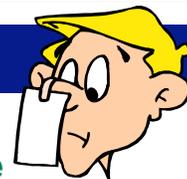
Under most benefit Plans, the Fund provides participants with various types of disability benefits when they become disabled and are unable to work (see your Summary Plan Description and Schedule of Benefits for those available to you). To better help you to understand your disability benefits, we have summarized your options below. If you remain uncertain regarding your benefit entitlements, we urge you to contact the Fund's Member Services Department to discuss your individual circumstance.

- **Weekly Accident & Sickness Benefit (applies to participant only)** - If you are disabled due to a non-occupational or non-excluded auto related accident or sickness while you are actively employed and are unable to perform the regular duties of your employment, you may qualify to receive the Weekly Accident & Sickness Benefit. You will receive the weekly benefit amount and the maximum weeks available as indicated in your Schedule of Benefits. During the period you are receiving this benefit, you and your eligible dependents will remain eligible for all other plan benefits. Any remaining benefit bank weeks you have available will be applied once your Weekly Accident and Sickness benefit has been exhausted. You must **file for this benefit within one year** after the non-occupational or non-excluded auto related accident or sickness occurs.
- **Extension of Basic Benefits (applies to participant or eligible dependent)** - If you or your eligible dependent have a disability that began while covered by a Fund Plan your Basic Benefit may continue beyond the termination of your coverage and you may qualify to have basic medical and hospital benefits extended for up to 90 days at no cost. This is limited to the treatment received for the continuing disability only and benefits are applied the same as if you were actively working. You are responsible for providing the Fund with documentation validating that disability. Documentation from your physician validating the disability must be **filed within one year** from the date your active coverage ceases.
- **Extension of Major Medical Benefits (applies to participant or eligible dependent)** - If you or your eligible dependent have a disability that began while covered by a Fund Plan your Major Medical Benefit may continue beyond the termination of your coverage and you may qualify to have your Major Medical Benefits extended for up to two years at no cost. This coverage is limited to the treatment received for the continuing disability only and benefits are paid at the out-of-network benefit level listed in your Schedule of Benefits. You are responsible for providing the Fund with documentation validating that disability. Documentation from your physician validating the disability must be **filed within one year** from the date your active coverage ceases.
- **Total and Permanent Disability Benefit (applies to participant only)** If you have a disability that is expected to continue for the remainder of your life and that causes you to be unable to engage in any regular employment or occupation for compensation, profit or gain for which you may be suited by your education, training or experience, you may be qualified to apply for Total and Permanent Disability Benefits. This benefit pays a monthly amount directly to you for a predetermined length of time but does not provide medical care or hospitalization coverage. In order to be considered for the Total and Permanent Disability benefit, you are required to fill out an application form. You may obtain application forms from the Fund's website at [www.mctwf.org](http://www.mctwf.org) or by contacting the Fund's Member Services Department at 313-964-2400. All claims must be **filed within one year** after the end of your active coverage under the Plan. Applications will be denied if they are received after the one-year period. While collecting the Total and Permanent Disability Benefit, you may also be eligible for the Extension of Basic Benefits or the Extension of Major Medical Benefits listed above.

If you are **retiring because of a disability**, you should contact the Fund's Member Services Department immediately so that we may help you to determine which benefit options would be in your best interests to select.



# REMINDERS



## Thinking of Retiring?

Are you thinking of Retiring? If so, before you make that decision please take into account the number of Fund rules and issues that need to be addressed in order to retire and participate in the Fund's Retiree Medical Program. For example, you must apply for Retiree Medical Program coverage (application is available on the Fund's website at [www.mctwf.org](http://www.mctwf.org)) within 90 days following the Retirement Date. For Fund purposes, 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.

We encourage you to call the Fund's Member Services Department to insure that you have done everything you need to do to protect your eligibility before you retire.

## Attention Medicare Eligible Retirees

If you are a Retiree (age 65 or under) and you or your spouse become eligible for Medicare benefits, entitlement to coverage through the Fund ceases on that date for the Medicare eligible person.

The Retiree Benefit Plan is designed to provide health care benefits until you or your spouse become eligible for Medicare. **It is your responsibility to notify the Fund when you become eligible** to avoid any claim overpayments for which you will be responsible.

The Fund must receive this notification in writing, with a copy of the eligible person's Medicare card or a letter from the Social Security Administration stating the effective eligibility date. Please include the retiree's social security number.



### IMPORTANT!

When providing any communication to the Fund's Correspondence Department (for example balance due bills, benefit questions, claims inquiries etc.), it is very important that you include the Fund Participant (social security) Number. Please also remind your physician to include this number on all requests to the Fund. This will help us respond to your issues in a more timely manner.

## Co-Payment Changes

Please be reminded that **effective March 1, 2004** co-payments for office visits and emergency room treatment for eligible participants enrolled in the SOA, TIF, I&S, PEP and UE medical plans will change to:

- In-Network Outpatient Office Visit Co-payment - \$20 per visit. This includes primary care physicians, specialists, and clinic visits (at a physician's office or outpatient at the hospital). **This does not include mental health and substance abuse visits which remain at \$15 per visit.**
- In-Network and Out-of-Network Emergency Room Visit Co-payment - \$20 per visit
- In-Network and Out-of-Network Hospital Admission co-payment - \$250 per admission **up to a maximum of three hospital admission co-payments per calendar year**; includes mental & nervous and substance abuse admissions.

**Please note:** The \$20 emergency room visit co-payment is waived in the event that the patient is admitted directly into the hospital, in which case only the \$250 admission co-payment applies. If the patient is re-admitted into the hospital within 30 days from the prior discharge for the same condition, the \$250 co-payment for the re-admission will be waived.

## Change in COBRA Rate Structure

COBRA provides you and your dependents with the right to continuation of medical coverage under your Plan in the event that your coverage ends due to certain qualifying events (see your Summary Plan Description for details).

Currently, the Fund offers composite (one-tier) contribution rates to those who wish to participate in a Fund Plan due to a COBRA qualifying event, regardless of their family status. The Trustees have determined that participants would be better served with a two-tier structure, providing single and family rates. Therefore, effective April 1, 2004, for all COBRA events occurring on or after that date, the Fund will be offering COBRA coverage at single rates (participant only) and family rates (participant with eligible spouse and/or dependent children). Single rates will be approximately 60% lower than family rates. Those participants who have enrolled in a COBRA plan prior to April 1, 2004 will remain on a composite rate basis for as long as they remain eligible for COBRA coverage, based on the qualifying event that occurred prior to April 1, 2004.



## Mental & Nervous and Substance Abuse Inpatient Day Limits Change

The Trustees have reviewed the Fund's Mental & Nervous and Substance Abuse benefits with their ValueOptions behavioral health consultant and have determined that inpatient benefits are in need of updating.

Under the current benefit plan provisions, subject to prior authorization and case management by ValueOptions –

- participants are entitled to 50 inpatient and outpatient professional visits, in aggregate, for all Mental & Nervous and/or Substance Abuse treatments per calendar year. The Trustees have determined that this provision is still appropriate.
- participants are entitled to 60 in-network (45 out-of-network) Mental & Nervous treatment inpatient days (continuously renewable after each 60 day period) and 42 inpatient days lifetime for Substance Abuse treatment. The Trustees have determined the Mental & Nervous inpatient days limit to be excessive and the Substance Abuse inpatient days limit to be inadequate.

In addition, the current Plan design does not address a now common approach known as intensive outpatient (IOP) treatment, which is utilized by behavioral health professionals in lieu of extended inpatient confinements to facilitate treatment and reduce recidivism through controlled and structured reintegration of patients into their normal living and working environments.



**Prior authorization is required. Please call:  
1-800-457-8540**

The Trustees considered the many common elements of Mental & Nervous and Substance Abuse disorders and noted that distinguishing between the two is often difficult and subjective. **Accordingly and in light of the current disparity in inpatient day limits, they have determined that there shall be one combined benefit limit of 45 days per calendar year for inpatient Mental & Nervous and Substance Abuse treatment, effective January 1, 2004.**

The Trustees have further determined that, based upon comparative expense, each nonresidential intensive outpatient day will count as one third of an inpatient day and each residential intensive outpatient day (referred to as IOP with domiciliary component) will count as one half of an inpatient day (and thus will reduce the inpatient day balance accordingly).



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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.

**MICHIGAN CONFERENCE OF  
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*



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**Anti-Fraud Hotlines**

While only a small number of providers engage in fraudulent activities, the impact can be significant both to the Fund and to you as well. We seek your help by reporting incidents of attempted fraud.

Each time you receive services from your medical, dental, or optical provider, you will receive an Explanation of Benefits statement. Please review the statement carefully and look for evidence of mistake or fraud such as:

- Services listed that you believe were not performed
- More expensive services than those actually performed
- The patient name listed is not the actual patient who received the services
- Non-covered services that were billed as covered services
- Service dates that do not match your appointment dates
- Charges listed that do not match your records

If you spot any of the above discrepancies or if you are otherwise aware of a mistake or possible fraud, please call the applicable anti-fraud hotline listed below:

**1-800-637-6907 for Medical and Optical Claims  
1-800-524-0147 for Dental Claims**

**Flu Mist™ Reimbursement**

FluMist™, the (weakened) live intranasal influenza virus vaccine was introduced in 2003 for the prevention of influenza A and B viruses in healthy individuals ages 5 to 49 years old.

With the recent shortage of the “flu shot”, (inactivated influenza vaccine given by injection) many participants and their dependents chose to be vaccinated by way of FluMist™ as it was readily available. If you or your eligible dependent received the vaccination and paid for it out-of-pocket you are eligible for reimbursement according to the applicable plan provisions and deductible and coinsurance requirements. The maximum allowable benefit for the FluMist™ vaccination is \$43 for the vaccine and \$10 for the administering fee.

To receive reimbursement according to the in-network or out-of-network reimbursement level indicated in your Schedule of Benefits, an itemized bill should be submitted to the Fund for out-of-network claims and directly to PPOM by the participating provider for in-network claims.