Michigan Conference of Teamsters Welfare Fund

MESSENGER

www.mctwf.org SUMMER 2022 VOLUME 39, ISSUE 2

Message from MCTWF's Executive Director

Dear Teamster Families,

I'd like to take this opportunity to welcome our newest Trustee, Ann R. Zick, to the MCTWF Board of Trustees. She is currently the Corporate Director of Employee and Labor Relations for Republic National Distributing Company. She has been a leader in employee and labor relations for more than 30 years, and she is a great addition to our board.

In this issue of the Messenger, you will find an article on the No Surprises Act (NSA). The NSA aims to help patients understand health care costs in advance of care, and it helps protect patients from unexpected "surprise billing." Please take a moment to review this important notice.

As we head into the middle of summer, there is no time like the present to focus on wellness and your overall health. MDLIVE, our telehealth provider, has expanded its behavioral health services to serve our members better. Your mental health is as important as your physical health. Providing quality benefits is paramount to our mission, and we encourage you to explore all the health and wellness benefits available to you as outlined in the new Summary Plan Description (SPD). If you have not received it already, the SPD is on its way to you through direct mail, and it is available now on our website at www.mctwf.org.

Wishing you and your families good health and happiness. Have a wonderful summer!

Kyle R. Stallman

We welcome our most recently enrolled participants and their family members, including the following groups:

Local Union 337, Detroit, MI
Woodbridge Productions, Inc. – City Primeval
US Foods, Inc. – Kalkaska-Saginaw
Starz Family Productions, Inc. – Black Mafia Family #2
North Center Productions, Inc. – Computer School

Local Union 406, Grand Rapids, MI
Minnesota Limited – Grand Traverse County & Crystal Falls
Intercon Construction, Inc. – Traverse City

Local Union 247, Detroit, MI
Atlantic Plant Maintenance, Inc.

Local Union 332, Flint, MI
Pe Ben USA, Inc.

Local Union 722, LaSalle, IL
Emulsicoat, Inc.

Inside This Issue

Important Notice:
Federal No Surprises Act Now in Effect

The Federal No Surprises Act (NSA) became effective April 1, 2022. The law aims to help patients understand health care costs in advance of care and to minimize unforeseen or "surprise" medical bills.

Unforeseen medical bills can happen when a patient receives emergency or scheduled clinical care or services from a provider or facility that is considered out-of-network or non-participating by that patient's insurance plan. Sometimes a patient is unaware they are receiving out-of-network services. These surprise bills are often called "balance billing" or "out-of-network billing." Providers and facilities are required to provide you with the following information regarding the NSA.

An exception to federal surprise billing protections is allowed if patients give prior written consent to waive their rights under the NSA and be billed more by out-of-network providers. Providers are never allowed to ask patients to waive their rights for emergency services or for certain other non-emergency services or situations addressed in the NSA.

Your Rights and Protections Against Surprise Medical Bills*

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

*The information contained in this notice, and additional details, can be found by visiting https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

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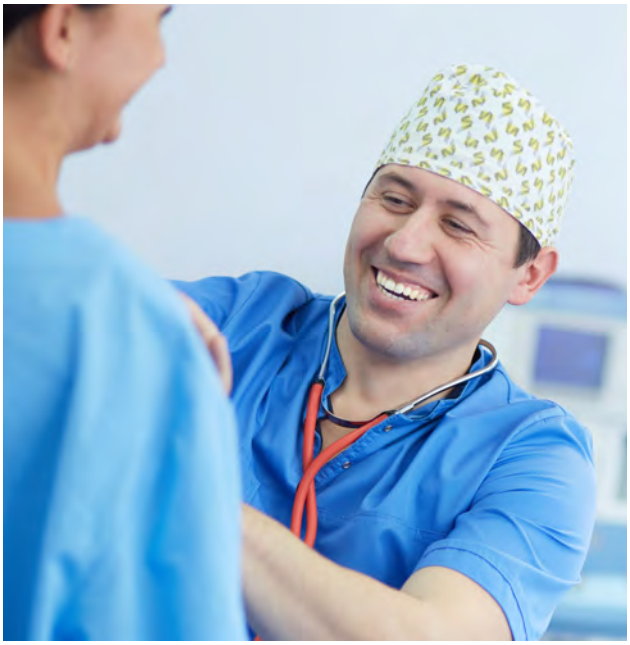


You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - » Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Centers for Medicare & Medicaid Services (CMS) No Surprises Help Desk at (800) 985-3059 from 8 a.m. to 8 p.m. EST, seven days a week, for questions/complaints or visit https://www.cms.gov/nosurprises for additional information about your rights under federal law.

MCTWF medical benefits are in compliance with the No Surprises Act.

Important Update: Emergent Conditions Definition

In accordance with the No Surprises Act, effective with dates of service on or after April 1, 2022, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, for a pregnant woman, the health of the women or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

In general, emergency room treatment for medical conditions that do not require immediate attention (to prevent death or serious bodily harm), including chronic medical problems, is not covered as a benefit. However, the Fund has made arrangements with Blue Cross Blue Shield of Michigan (BCBSM) that will avail members of Blue Cross Blue Shield (BCBS) discounts. The Fund will "approve" emergency room facility claims and emergency room physician claims for treatment of non-emergent conditions, thereby triggering the BCBS discounts.

The Fund will continue not to pay any portion of the non-emergent emergency room facility claims, but will make payment toward the non-emergent emergency room physician claims in an amount approximately equivalent to what the Fund would have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by the Fund's payment at the urgent care rate for those services. For conditions that require medical attention and cannot wait for an appointment with your physician, but are not "emergent," treatment should be sought from an urgent care center.

All emergency room claims incurred by individuals that are billed with a non-emergent condition diagnosis are reviewed for medical necessity based on the above criteria. Should the use of the emergency room be determined to not have been medically necessary, you will be responsible for payment.

Chiropractic Services Benefit Update

The MCTWF Actives Plan and MCTWF Retirees Plan pays for 24 spinal manipulations (once per day per person annually), one new patient office visit every 36 months and one established patient office visit annually, per chiropractor. The chiropractic services for those diagnoses deemed by Blue Cross Blue Shield of Michigan (BCBSM) as treatable with chiropractic services are as follows:

- Nonallopathic lesions –
  - cervical region;
  - head region;
  - lumbar region;
  - sacral region; and
  - thoracic region.
- Other, multiple, and ill-defined dislocations –
  - first through the seventh cervical vertebra;
  - multiple cervical vertebrae; and
  - thoracic, lumbar, coccyx and sacrum vertebra, closed (i.e., non-exposed).

Effective 5/5/22, the "Per Day" limit for spinal manipulations has been removed, but the annual limit does not change.

Colonoscopy Wellness Benefit Changed to Age 45

Colonoscopy or flexible sigmoidoscopy screening is provided once every five years to those age 45 years and older (reduced from 50 in prior years).

On a one time only basis, if the colonoscopy follows a sigmoidoscopy, the five-year limitation does not apply.

The MCTWF Actives Plan and MCTWF Retirees Plan pays for periodic health examinations and services. Applicable deductible, copayment, and coinsurance amounts for services rendered by network providers will be waived. Services rendered by out-of-network providers will be subject to out-of-network deductible, copayment and coinsurance amounts. In-network providers can be found by visiting www.mctwf.org on the "Provider Networks" tab.

MCTWF provides an array of wellness benefits for members. For all the details, refer to your Summary Plan Description.

MCTWF's New Summary Plan Description is Available and On the Way!

A new Summary Plan Description (SPD) booklet is on the way to participants. The SPD provides general information about the MCTWF Actives Plan and MCTWF Retirees Plan effective as of April 2022. Along with the SPD, you will receive the MCTWF Schedule of Benefits specific to your benefit package that describes what benefits are covered and your cost sharing requirements.

The Summary Plan Description is required by The Employee Retirement Income Security Act (ERISA) of 1974. The purpose of this Summary Plan Description is to acquaint participants with the provisions of the MCTWF plans, the way in which they are administered, and participants' rights under the federal law which applies to employee benefit plans.

Every effort has been made to make this Summary Plan Description as accurate as possible. All updates to the plan are mailed to participants in the form of the *Messenger* newsletter and other direct mailings. The new SPD is also available on the website at www.mctwf.org. A new *Messenger* Compilation will also be available on the website. An archive of past *Messengers* is located on the website at www.mctwf.org.

Physical Wellness Checklist

We know that making healthy choices can help us feel better and live longer. Maybe you've already tried to eat better, get more exercise or sleep, quit smoking, or reduce stress. It's not easy, but research shows how you can boost your ability to create and sustain a healthy lifestyle.

TO BUILD HEALTHY HABITS:

- Plan. Identify unhealthy patterns and triggers. Set realistic goals.
- Change your surroundings. Find ways to make healthier choices easy choices. Remove temptations. Look for changes in your community, like safe places to walk.
- Ask for support. Find friends, family, co-workers, neighbors, or groups for support.
- Fill your time with healthy activities. Try exercise, a favorite hobby, or spending time with family and friends.
- Track your progress. Record how things are going to help you stay focused and catch slip-ups.
- Imagine the future. Think about future benefits to stay on track.
- Reward yourself. Give yourself a healthy reward when you've achieved a small goal or milestone.
- Be patient. Improvement takes time, and setbacks happen. Focus on progress, not perfection.

Information in this article is provided by the National Institute of Health. For other wellness topics, please visit www.nih.gov.

MDLIVE Offers Behavioral Health Options

Since every May marks Mental Health Awareness month, it's important to note that MDLIVE, one of MCTWF's telehealth providers, has expanded its behavioral health services.

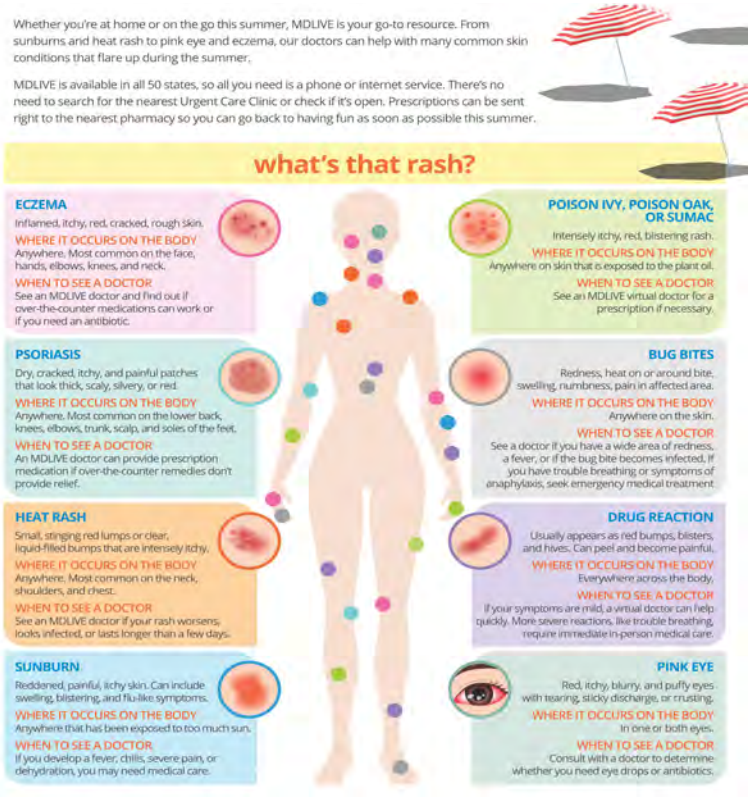
MDLIVE offers the following reasons for MCTWF members to explore their behavior therapy services:

- Have your first therapy appointment in less time compared to the weeks or months it takes to schedule an in-person appointment.
- Easy to find a match – With thousands of licensed therapists in the MDLIVE network, it's easy to find a therapist that's the right fit for you.
- Flexibility – Choose the same provider for every visit or switch at any time. Convenient times are available, including weekends and evenings.
- Experience – MDLIVE licensed therapists have an average of over ten years of experience. MDLIVE licensed therapists and board-certified psychiatrists can get you back to feeling your best if you're feeling overwhelmed, stuck, or not like yourself. Common reasons to seek care include:
  - Addictions
  - Bipolar Disorders
  - Child and Adolescent Issues
  - Depression
  - Eating Disorders
  - Gay/Lesbian/Bisexual/Transgender Issues
  - Grief and Loss
  - Life Changes
  - Men's Issues
  - Panic Disorders
  - Parenting Issues
  - Postpartum Depression
  - Relationship and Marriage Issues
  - Stress
  - Trauma and PTSD
  - Women's Issues
  - General Support

All MDLIVE mental health professionals hold current licenses and have experience providing mental health support. They also have experience in telehealth, which can make for a smoother transition when getting started with online therapy. Available professionals may depend on your location, but you can choose from distinct types of mental health professionals, such as: licensed clinical social workers, licensed professional counselors, licensed mental health counselors, licensed family therapists, psychologists, and psychiatrists.

MDLIVE members can review a therapist's profile and credentials before booking an appointment.

Make it a Healthy Summer with MDLIVE



Livongo® for Diabetes Management

It's all for you and on the house.

YOUR VERY OWN COACH

Meet with your personal coach regularly to gain tips and tools to help you stick with it and succeed (motivation and virtual high-fives are included!).

ANYTIME ACCESS

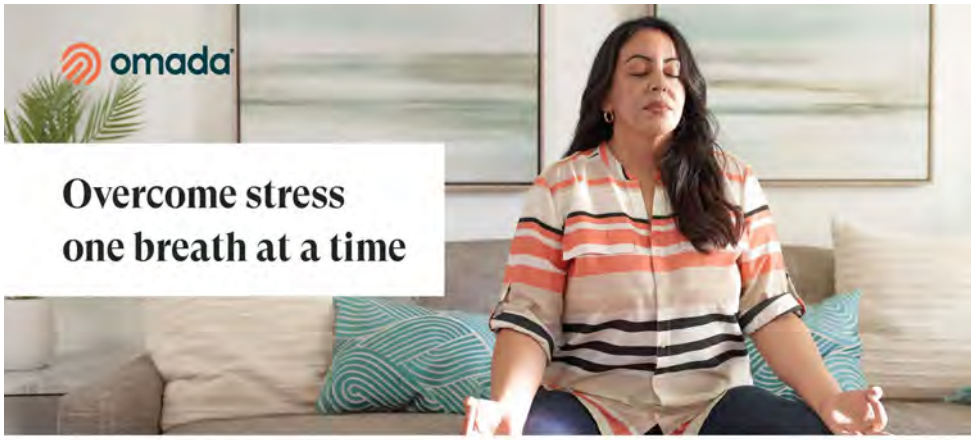
Our coaches are available 24/7. If your blood sugar is out of range, we'll offer guidance to help you get back on track.

A MEAL PLAN JUST FOR YOU

Work with our Livongo coaches to create an individualized plan that includes the best foods for you, smarter snacks, and strategies for staying on target.

Diabetics can join for free by visiting https://welcome.livongo.com/mctwf or calling Livongo Member Support at 1-800-945-4355 . Use registration code "MCTWF".

Omada® for Pre-Diabetes and Weight Management



Start a Deep-Breathing Practice

Use breathing to lower stress levels for a healthier happier you.

With Omada learn ways to not only destress and improve your quality of life, but how to keep your stress levels lower on a day to day basis. The best part is you're already covered!

Join today:
omadahealth.com/mctwf

Start feeling better today:

- ✓ Relax your body
- ✓ Start your breathing
- ✓ Enjoy a healthier happier you!

Five Steps to Deep Breathing From Omada

Step 1
Relax your body. Find somewhere to sit or lie down comfortably.

Step 2
Close your eyes and inhale slowly through your nose. Feel your breath as it flows down and causes your belly to expand.

Step 3
At the end of your inhale, pause for a few seconds, then exhale fully through your mouth.

Step 4
It's all about focus. Pay close attention to your breath as it goes in and out of your body.

Step 5
Your attention will wander – that's fine – just refocus on your breathing.

New MCTWF Participant Web Portal Coming Soon

MCTWF is in the process of upgrading the Participant Portal. This useful tool provides access to your protected health information maintained by MCTWF through a fully secured personal account and is accessible from our website home page at www.mctwf.org.

Expected to launch soon, the new "Participant Web Portal" will provide improved navigation and appearance.

Everyone who wishes to access the new portal will be required to create an account – even if you have an account on the current portal. By creating a new Participant Web Portal account when it becomes available, you will continue to have access to:

- Participant screen which displays the participant's contract number, date of birth, gender, current benefit plan, number of benefit bank weeks remaining, if applicable, current address, phone number and marital status. If you find that your address or phone number information is not correct, you can go to the Account Maintenance screen to update and submit the corrected information.
- Family screen that displays each covered family member's name, date of birth, relation to participant, and the date through which coverage is available.
- Eligibility History screen covers all periods of eligibility for each family member.
- Plan Limits screen displays your family and individual accruals for the current and prior calendar year towards calendar year dollar limits available and used for applicable medical and dental benefits.
- Claims screen gives you the ability to reprint any Explanation of Benefits (EOB) as well as update beneficiaries and account information.

Short-Term Disability

Weekly Accident and Sickness (A&S) benefits provide short-term disability income and eligibility for other benefit package components, if applicable, during the covered period of a disability. MCTWF Actives Plan participants who are eligible under a benefit package that provides weekly A&S benefits, will receive such benefits only if the participant ceased work as the result of a non-occupational disability due to illness, non-auto-related injury (however, if auto-related, participants do remain eligible for disability income benefits), or pregnancy. Beneficiaries (i.e., spouse and dependent children) are not eligible to receive this benefit. Full benefit details are described in your Summary Plan Description.

To qualify for A&S benefits, all five of the below requirements must be met. The participant must:

- have established eligibility; and
- be reported as an actively working employee of a contributing employer at the time the disability commenced; and
- have contributions paid on his behalf from the participating employer to cover the commencement of the disability (i.e., the date established) which means the date established by the medical provider upon which the participant first became disabled; and,
- be losing time from work due to the disability, i.e., A&S benefits are not payable if the disability occurs while laid-off, on personal leave, on sanctioned strike or lockout, temporary work stoppage (strike or lockout) etc.; and,
- under the regular care of a licensed physician who confirms the disability and submits a *Participant Report of Disability* form completed by the physician, participant, and employer when requested.

Once the participant establishes eligibility, weekly accident and sickness benefits may begin on –

- the first day following medical attention after the last day worked in the event of an accidental injury, providing that the participant is eligible for benefits on the date that the medical attention was received. Thus a) if medical attention is received on the last day worked, benefits would commence effective the following day or b) if medical attention is first received on a subsequent day, benefits would commence effective the day the medical attention is received; or the –
- eighth day following medical attention after the last day worked in the event of a sickness, providing that the participant is eligible for benefits on the date that the medical attention was received. Thus a) if medical attention is received on the last day worked, the first of the eight day elimination period would be the following day and therefore benefits would commence effective the same day of the week in the following week or b) if medical attention is first received on a day subsequent to the last day worked, the first day of the eight day elimination period would be the day the medical attention is received and therefore benefits would commence effective the same day of the week in the following week.

The participant will receive an established amount each week up to an established maximum number of weeks for each period of disability provided he is –

- unable to perform his duties of the job; and
- under the regular care of a licensed physician who confirms the participant's disability by submitting a monthly *Participant Report of Disability* form completed by the physician, the participant, and his employer. Physicians who are authorized to make such determination under a MCTWF Actives Plan of benefits must be either a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M), or an Oral Surgeon.

During partial weeks of disability, the participant will receive a daily benefit equal to one-seventh of the weekly amount.

Note: Once the participant retires, he/she is no longer eligible for A&S benefits. If any A&S benefits are paid beyond the retirement date, or the date the participant is no longer eligible for the benefit, the participant will be pursued for the A&S benefit overpayment.

The *Messenger* 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.

Visit us at www.mctwf.org for more benefit information!

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND
2700 TRUMBULL AVE.
DETROIT, MICHIGAN 48216
313-964-2400
TOLL FREE 800-572-7687
IN CASE OF OUTAGE: 800-482-2219

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

Drug Category – Vision Enhancement Agents

CVS/Caremark has established a new drug category called Vision Enhancement Agents. This category currently contains the following prescription ophthalmic products used to improve field of vision: Vuity (pilocarpine, AbbVie), Upneeq (oxymetazoline, RVL Pharmaceuticals), and Acuvue Theravision (etafilcon).

These three prescription medications are considered cosmetic and therefore are not covered under your MCTWF benefit package effective August 1, 2022.

This excluded category of ophthalmic prescription medications will be updated as additional products become U.S. Food and Drug Administration approved.

KERENDIA® (finerenone) Medication

Kerendia (finerenone) oral tablets were approved by the FDA on July 9, 2021, to reduce the risk of kidney function decline, kidney failure, cardiovascular death, non-fatal heart attacks, and hospitalization for heart failure in adults with chronic kidney disease associated with type 2 diabetes. Kerendia is a non-specialty brand medication.

To ensure appropriate use of this new therapy, prior authorization will be required effective July 15, 2022. To obtain approval to have this medication covered, the prescribing physician must contact CVS/Caremark at (800) 626-3046.

If, in reviewing an Explanation of Benefits from MCTWF, or from one of its business associates, you identify what you believe to be fraudulent information, please contact the appropriate toll-free Anti-fraud Hotline as follows:

For Physician or Vision Claims: (800) 637-6907
For Dental Claims: (800) 524-0147
For Hospital Claims: (800) 482-3787

Editor's Note:

For simplicity, the *Messenger* may use masculine pronouns to refer to a participant (i.e., employee) and female pronouns to refer to dependents. When referring individually or collectively to participants and beneficiaries (i.e., spouses and eligible children), the *Messenger* uses the term "members." Michigan Conference of Teamsters Welfare Fund is referred to as "Fund" or "MCTWF".

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Michigan Conference of Teamsters Welfare Fund.