



# SUMMARY PLAN DESCRIPTION



**Michigan Conference of  
Teamsters Welfare Fund  
Summary Plan Description Booklet**

**All Plans**  
April 2010



## **IMPORTANT – PLEASE NOTE**

This Summary Plan Description Booklet, together with your Plan's Schedule of Benefits, and any material modifications thereof, as published hereafter in the Michigan Conference of Teamsters Welfare Fund's (MCTWF's) newsletter, the *Messenger*, constitute your Summary Plan Description and Plan Document.

This Summary Plan Description Booklet is general in nature, for use in connection with all MCTWF Plans of Benefits. Accordingly, some of the benefits described herein may not be covered under your MCTWF Plan. If you have any questions about your benefits, please contact MCTWF's Customer Communications Department.

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Detroit, Michigan 48216  
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[www.mctwf.org](http://www.mctwf.org)

# IMPORTANT PHONE NUMBERS

**For verification of eligibility, benefits or to determine the status of a claim, participants and providers call MCTWF's Customer Communications Department -**

Local Calls .....(313) 964-2400  
Toll free.....(800) 572-7687

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**For participating provider referrals, after hours, participants call -**

Blue Cross Blue Shield .....(800) 810-2583  
Delta Dental of Michigan and DeltaVision .....(800) 524-0149

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**For prescription drug Mail Service and Retail Pharmacy matters, participants and providers call -**

CVS Caremark .....(888) 727-0495

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**For prior authorization of Acne, SSRI, Anti-Obesity, ADHD/Narcolepsy (age 20 and above), Anabolic Steroids and Oral Anti-Fungal medications, providers call -**

CVS Caremark .....(800) 626-3046

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**For prior authorization of non-emergent outpatient CT Scans, MRIs, PET Scans and Nuclear Cardiology, providers in Michigan call BCBS. Non-BCBS and Non-Michigan providers call MCTWF's Utilization Review Department -**

Blue Cross Blue Shield - American Imaging Management .....(800) 728-8008  
MCTWF Utilization Review Department ..... (800) 572-7687 ext. 428

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**For prior authorization of Skilled Nursing Facility Care, providers in Michigan call BCBS. Non-BCBS and Non-Michigan providers call MCTWF's Utilization Review Department.**

Blue Cross Blue Shield .....(800) 482-4040  
MCTWF Utilization Review Department ..... (800) 572-7687 ext. 428

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**For prior authorization of Home Health Care and Hospice Care, providers call MCTWF's Utilization Review Department -**

Local Calls .....(313) 964-2400 ext. 428  
Toll Free ..... (800) 572-7687 ext. 428

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**For prior authorization of Human Organ Transplant Procedures, providers in Michigan call BCBS. Non-BCBS and Non-Michigan providers call MCTWF's Utilization Review Department.**

Blue Cross Blue Shield .....(800) 242-3504  
MCTWF Utilization Review Department ..... (800) 572-7687 ext. 428

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**For prior authorization of Mental Health and Substance Abuse Treatment, participants and providers call -**

ValueOptions .....(800) 457-8540

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**For Medical, Dental, Optical and Hospital claims fraud matters, participants call -**

For Professional Medical claims - call MCTWF .....(800) 637-6907  
For Dental or Optical claims - call Delta Dental of Michigan .....(800) 524-0147  
Hospital claims - Blue Cross Blue Shield of Michigan .....(800) 482-3787

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# INTRODUCTION

This Booklet, which provides general information about your Michigan Conference of Teamsters Welfare Fund (MCTWF) benefit Plan, the accompanying Schedule of Benefits and MCTWF *Messenger* newsletters published hereafter comprise your Summary Plan Description (SPD). The SPD is the Master Plan Document. It is available for your review at 2700 Trumbull Avenue, Detroit, Michigan 48216 between 8:30 a.m. and 5:00 p.m. on regularly scheduled business days.

Your SPD Booklet will help you understand your benefits and use them well. You should review it with those of your family members Covered by your MCTWF Plan. If you are married please be sure to share your SPD Booklet with your Spouse. It will give all of you an understanding of -

- when coverage begins and ends;
- the benefits provided;
- the procedures to follow in submitting claims and appeals; and
- your responsibility for providing necessary information to your MCTWF Plan.

When your MCTWF Plan is amended, from time to time, you will be notified through MCTWF's *Messenger* newsletter. As noted above, the *Messenger* is part of and updates your SPD Booklet.

Be sure to keep this Booklet and accompanying Schedule of Benefits, along with your *Messenger* newsletters in a safe and convenient place where you can find and refer to them. You may also access each of these documents on MCTWF's website, which also provides, for your further convenience, a Compilation of *Messenger* Notifications. If there is anything about these benefits that you don't understand, contact the MCTWF Customer Communications Department. They will be happy to assist you.

You may also obtain valuable information that will help you find the things you need to know about your Plan of benefits on MCTWF's website at [www.mctwf.org](http://www.mctwf.org). There you can access your SPD Booklet, Schedule of Benefits, and *Messenger* newsletters, conduct provider Network searches, retrieve and print forms, research HIPAA Privacy Rules and access other key MCTWF information.

The Trustees have the right to modify, revoke, suspend, terminate or change these benefits and/or provisions, in whole or in part, at any time without prior notice. If MCTWF is terminated, the Trustees may use its remaining assets, after paying claims, to pay its remaining expenses, or may contribute those remaining assets to a new welfare benefit Plan established through collective bargaining.

MCTWF will terminate your coverage if the Trustees, in their sole discretion, determine that you, or your legal representative, knowingly provide false information, directly or indirectly, with the intent to cause MCTWF to provide coverage, benefits, or payments that you or a third party is not entitled to receive.

No document, including financial instruments such as checks or money orders, shall be presumed to have been received by MCTWF unless actually received, regardless of the circumstances of mailing.

For simplicity, unless otherwise stated this SPD Booklet refers to "you" for both the Participant and Dependents who are Covered under the Participant's Plan of benefits, "he" when referring to the Participant, and "she" when referring to the Participant's Spouse.

Benefit programs are capitalized, form names are italicized and capitalized terms are defined at the end of this Booklet. We have made one exception with regard to the word "you", which for ease of reading we have chosen not to capitalize. However, all references to the word "you" in this Booklet shall mean you and your eligible dependents.

Please refer to your Schedule of Benefits to determine what benefits are covered under your MCTWF Plan and how they are paid.

# TABLE OF CONTENTS

<b>Part 1: GENERAL EXCLUSIONS AND LIMITATIONS</b>	<b>1</b>
<b>Part 2: ELIGIBILITY</b>	<b>2</b>
<b>SEC. 2.1: ACTIVE BENEFIT PLANS</b>	<b>2</b>
<b>(a) ENROLLING IN THE PLAN</b>	<b>2</b>
<b>(b) UPDATING ENROLLMENT INFORMATION</b>	<b>3</b>
Family Status Changes	3
Participant Information Changes	3
Qualified Medical Child Support Orders (QMCSOs)	4
<b>(c) ELIGIBILITY FOR COVERAGE</b>	<b>4</b>
Eligibility for Coverage Based on Weekly Contributions	5
Eligibility for Coverage Based on Hourly/Daily Contributions	5
<b>(d) COVERING YOUR DEPENDENTS</b>	<b>6</b>
<b>(e) LOSS OF ELIGIBILITY</b>	<b>8</b>
<b>(f) IF YOUR EMPLOYMENT ENDS</b>	<b>8</b>
Termination	8
Layoff	9
<b>(g) IF YOUR EMPLOYER WITHDRAWS FROM MCTWF PARTICIPATION</b>	<b>9</b>
<b>(h) BENEFIT BANK WEEKS</b>	<b>9</b>
Using Your Benefit Bank Weeks	9
<b>(i) STRIKE OR LOCKOUT</b>	<b>10</b>
<b>(j) LEAVES OF ABSENCE</b>	<b>11</b>
Family and Medical Leaves	11
Military Leave	12
Other Leaves	12
<b>(k) INJURY OR ILLNESS</b>	<b>12</b>
<b>(l) REINSTATEMENT OF COVERAGE</b>	<b>12</b>
<b>(m) DEATH</b>	<b>13</b>
<b>(n) FLEXIBLE DEPENDENT COVERAGE PROGRAM</b>	<b>13</b>
How to Enroll	14
Change In Family Status	14
<b>SEC. 2.2: COBRA CONTINUATION COVERAGE</b>	<b>14</b>
<b>(a) COVERAGE ENTITLEMENT PERIOD</b>	<b>15</b>
When COBRA Continuation Coverage Continues For Up to 18 Months	15
When COBRA Continuation Coverage Continues For Up to 29 Months	15
When COBRA Continuation Coverage Continues For Up to 36 Months	15
<b>(b) HOW TO ELECT COBRA CONTINUATION COVERAGE</b>	<b>16</b>

(c) MEDICARE ENROLLED INDIVIDUALS ELECTING COBRA CONTINUATION COVERAGE .....	17
(d) NOTIFYING MCTWF OF DEPENDENT COBRA QUALIFYING EVENT .....	17
(e) LOSS OF COBRA CONTINUATION COVERAGE .....	17
(f) CERTIFICATE OF CREDITABLE COVERAGE .....	18
<b>SEC. 2.3: RETIREE BENEFIT PLANS.....</b>	<b>18</b>
(a) RETIREE MEDICAL PROGRAM .....	18
Eligibility for Participation .....	18
Participants Age 57 or Older.....	18
Participants Under Age 57 .....	18
Retiree Supplemental Benefits Rider.....	19
Uniformed Services (Military Leave) .....	19
Enrollment and Contributions .....	19
COBRA Continuation Coverage Contributions .....	20
Restriction on Program Participation .....	20
Eligibility For Deferred Participation in the Program.....	20
Automatic Deferrals.....	20
Voluntary Deferrals.....	20
When Your Coverage Begins .....	21
Covering Your Spouse .....	21
Termination of Retiree Medical Program Eligibility .....	22
When Your Spouse’s Retiree Medical Program Coverage Ends .....	22
Recognition of Other Fund Participation - Reciprocity .....	23
(b) RETIREE DEATH BENEFIT PROGRAM .....	23
Enrolling .....	23
Contributions .....	24
<b>Part 3: MEDICAL BENEFITS - ACTIVE &amp; RETIREE PLANS .....</b>	<b>25</b>
<b>SEC. 3.1: NETWORK AND OUT-OF-NETWORK PROVIDERS.....</b>	<b>25</b>
(a) WORLDWIDE NETWORK PROVIDERS.....	26
(b) CERTAIN OUT-OF-NETWORK PROVIDER SERVICES COVERED AT IN-NETWORK LEVELS ....	26
<b>SEC. 3.2: IF YOU DO NOT HAVE ACCESS TO NETWORK PROVIDERS .....</b>	<b>27</b>
(a) MEDICAL CARE .....	27
(b) NON-ACCESS EXEMPTION APPLICATION .....	27
<b>SEC. 3.3: USING YOUR IDENTIFICATION CARDS.....</b>	<b>27</b>
<b>SEC. 3.4: SCHEDULE OF BENEFITS .....</b>	<b>27</b>
<b>SEC. 3.5: MEDICAL EXPENSES - COST SHARING AND LIMITS.....</b>	<b>28</b>
(a) ALLOWED AMOUNTS .....	28

<b>(b) DEDUCTIBLE</b> .....	<b>28</b>
<b>(c) COINSURANCE</b> .....	<b>28</b>
<b>(d) COPAYMENT</b> .....	<b>28</b>
<b>(e) OUT-OF-POCKET MAXIMUM</b> .....	<b>28</b>
<b>(f) LIFETIME BENEFITS MAXIMUM</b> .....	<b>28</b>
<b>(g) MAXIMUM ALLOWABLE BENEFIT</b> .....	<b>28</b>
<b>SEC. 3.6: PRIOR AUTHORIZATION</b> .....	<b>29</b>
<b>SEC. 3.7: HOSPITAL</b> .....	<b>29</b>
<b>(a) ROOM AND BOARD</b> .....	<b>29</b>
<b>(b) OTHER HOSPITAL SERVICES</b> .....	<b>29</b>
<b>SEC. 3.8: SURGICAL</b> .....	<b>30</b>
<b>SEC. 3.9: SECOND AND THIRD MEDICAL OPINIONS</b> .....	<b>30</b>
<b>SEC. 3.10: DIAGNOSTIC IMAGING</b> .....	<b>30</b>
<b>SEC. 3.11: LABORATORY TESTS</b> .....	<b>30</b>
<b>SEC. 3.12: PHYSICIAN VISITS</b> .....	<b>31</b>
<b>SEC. 3.13: SKILLED NURSING FACILITY</b> .....	<b>31</b>
<b>SEC. 3.14: EMERGENCY SERVICES</b> .....	<b>31</b>
<b>SEC. 3.15: AMBULANCE SERVICES</b> .....	<b>31</b>
<b>SEC. 3.16: MATERNITY</b> .....	<b>32</b>
<b>(a) MIDWIFE SERVICES</b> .....	<b>32</b>
<b>SEC. 3.17: HOME HEALTH CARE</b> .....	<b>32</b>
<b>(a) NURSING CARE</b> .....	<b>33</b>
<b>SEC. 3.18: HOSPICE</b> .....	<b>33</b>
<b>SEC. 3.19: RESPITE CARE</b> .....	<b>33</b>
<b>SEC. 3.20: CHIROPRACTIC SERVICES</b> .....	<b>33</b>
<b>SEC. 3.21: OPHTHALMOLOGY AND OPTOMETRY SERVICES</b> .....	<b>34</b>
<b>SEC. 3.22: HEARING</b> .....	<b>34</b>
<b>(a) COVERED HEARING AID ITEMS</b> .....	<b>34</b>
<b>(b) HEARING AID ITEMS NOT COVERED</b> .....	<b>34</b>
<b>SEC. 3.23: DURABLE MEDICAL EQUIPMENT (DME)</b> .....	<b>35</b>
<b>SEC. 3.24: MEDICAL SUPPLIES</b> .....	<b>35</b>
<b>SEC. 3.25: WELLNESS</b> .....	<b>35</b>
<b>(a) TYPES OF COVERED SERVICES</b> .....	<b>36</b>
<b>SEC. 3.26: OTHER MEDICAL BENEFITS</b> .....	<b>37</b>
<b>(a) BREAST RECONSTRUCTION</b> .....	<b>37</b>
<b>(b) BARIATRIC SURGERY</b> .....	<b>37</b>
<b>(c) CARDIAC REHABILITATION</b> .....	<b>37</b>

(d) CHEMOTHERAPY AND RADIATION THERAPY .....	38
(e) COLONOSCOPY SCREENING .....	38
(f) DENTIST AND DENTAL SURGEON SERVICES.....	38
(g) DIALYSIS .....	38
(h) DIETARY COUNSELING .....	39
(i) EXPERIMENTAL, INVESTIGATIVE OR OTHERWISE NOT REASONABLE OR CUSTOMARY TREATMENT.....	39
(j) HYPERALIMENTATION (TPN) .....	39
(k) IMMUNIZATIONS .....	39
(l) INFUSION THERAPY.....	39
(m) INJECTIONS .....	39
(n) CONTRACEPTIVE MANAGEMENT .....	39
(o) INTRA-ARTICULAR INJECTIONS .....	39
(p) ORTHOTIC DEVICES .....	40
(q) PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY .....	40
(r) PROSTHETIC DEVICES.....	40
(s) SCLEROTHERAPY .....	40
(t) SLEEP STUDIES .....	41
(u) SPECIAL FORMULAS AND MEDICAL FOODS .....	41
(v) TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION .....	41
<b>SEC. 3.27: EXTENDED DISABILITY .....</b>	<b>41</b>
<b>SEC. 3.28: HUMAN ORGAN AND TISSUE TRANSPLANT .....</b>	<b>42</b>
(a) COVERED EXPENSES .....	42
(b) ORGAN TRANSPLANT DONOR COVERED EXPENSES .....	44
<b>SEC. 3.29: MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT .....</b>	<b>44</b>
<b>SEC. 3.30: MEDICAL EXPENSES NOT COVERED.....</b>	<b>45</b>
<b>PART 4: WEEKLY ACCIDENT AND SICKNESS BENEFITS .....</b>	<b>47</b>
<b>SEC. 4.1: HOW YOUR PLAN PAYS BENEFITS .....</b>	<b>47</b>
<b>SEC. 4.2: CONTINUATION OF BENEFIT ELIGIBILITY.....</b>	<b>47</b>
<b>SEC. 4.3: HOW BENEFITS ARE TAXED .....</b>	<b>47</b>
<b>PART 5: TOTAL AND PERMANENT DISABILITY BENEFITS .....</b>	<b>48</b>
<b>SEC. 5.1: BENEFIT AMOUNT AND DURATION .....</b>	<b>48</b>
<b>PART 6: PRESCRIPTION DRUG BENEFITS .....</b>	<b>49</b>
<b>SEC. 6.1: RETAIL (34) AND RETAIL (90) PHARMACY .....</b>	<b>49</b>
(a) FILLING A PRESCRIPTION AT A RETAIL PHARMACY .....	49

<b>SEC. 6.2: MAIL SERVICE PHARMACY .....</b>	<b>49</b>
<b>(a) FILLING A PRESCRIPTION THROUGH THE MAIL SERVICE PHARMACY .....</b>	<b>50</b>
<b>SEC. 6.3: SPECIALTY PHARMACY SERVICES .....</b>	<b>50</b>
<b>SEC. 6.4: PRESCRIPTION DRUG PRIOR AUTHORIZATIONS .....</b>	<b>51</b>
<b>SEC. 6.5: NON-SEDATING ANTIHISTAMINES AND PROTON PUMP INHIBITORS .....</b>	<b>51</b>
<b>(a) NON-SEDATING ANTIHISTAMINES - CRITERIA FOR AUTHORIZATION.....</b>	<b>51</b>
<b>(b) PROTON PUMP INHIBITORS - CRITERIA FOR AUTHORIZATION .....</b>	<b>51</b>
<b>SEC. 6.6: SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI) STEP THERAPY .....</b>	<b>52</b>
<b>SEC. 6.7: PRESCRIPTION DRUG LIMITATIONS .....</b>	<b>52</b>
<b>SEC. 6.8: PRESCRIPTION DRUG REIMBURSEMENT .....</b>	<b>52</b>
<b>SEC. 6.9: PRESCRIPTION DRUG EXPENSES NOT COVERED .....</b>	<b>53</b>
<b>SEC. 6.10: NOTICE OF CREDITABLE COVERAGE - ALL TIF, SOA, KEY, I&amp;S AND PEP PLANS ..</b>	<b>54</b>
<b>PART 7: DENTAL BENEFITS</b>	<b>56</b>
<b>SEC. 7.1: CHOICE OF DENTAL PROVIDERS .....</b>	<b>56</b>
<b>SEC. 7.2: PREDETERMINATION OF BENEFITS .....</b>	<b>56</b>
<b>(a) OBTAINING A PREDETERMINATION OF BENEFITS.....</b>	<b>56</b>
<b>SEC. 7.3: ALTERNATE PROCEDURES .....</b>	<b>57</b>
<b>SEC. 7.4: COVERED DENTAL EXPENSES.....</b>	<b>57</b>
<b>(a) COVERED DENTAL EXPENSES FOR HIGH RISK MEDICAL CONDITIONS.....</b>	<b>58</b>
<b>(b) COVERED DENTAL EXPENSES AFTER ELIGIBILITY CEASES .....</b>	<b>58</b>
<b>(c) OUT-OF-NETWORK SERVICES .....</b>	<b>59</b>
<b>SEC. 7.5: IF YOU DO NOT HAVE ACCESS TO NETWORK GENERAL DENTISTS OR ORTHODONTIC PROVIDERS .....</b>	<b>59</b>
<b>(a) NON-ACCESS EXEMPTION APPLICATION.....</b>	<b>59</b>
<b>SEC. 7.6: DENTAL EXPENSES NOT COVERED.....</b>	<b>60</b>
<b>PART 8: VISION BENEFITS</b>	<b>62</b>
<b>SEC. 8.1: CHOICE OF VISION PROVIDERS .....</b>	<b>62</b>
<b>SEC. 8.2: IN-NETWORK OPTION .....</b>	<b>62</b>
<b>SEC. 8.3: OUT-OF-NETWORK OPTION.....</b>	<b>62</b>
<b>SEC. 8.4: VISION EXPENSES NOT COVERED .....</b>	<b>63</b>
<b>PART 9: ACTIVE DEATH BENEFITS</b>	<b>64</b>
<b>SEC. 9.1: EMPLOYEE DEATH BENEFIT.....</b>	<b>64</b>
<b>SEC. 9.2: DEPENDENT DEATH BENEFIT .....</b>	<b>64</b>
<b>SEC. 9.3: HOW YOUR PLAN PAYS BENEFITS .....</b>	<b>64</b>

<b>PART 10: ACCIDENTAL DEATH AND DISMEMBERMENT</b>	<b>65</b>
SEC. 10.1: WHEN BENEFITS ARE NOT PAYABLE .....	65
<b>PART 11: RETIREE DEATH BENEFIT PROGRAM</b>	<b>66</b>
SEC. 11.1: HOW THE PROGRAM PAYS BENEFITS .....	66
SEC. 11.2: TERMINATION OF COVERAGE .....	66
<b>PART 12: FLEXIBLE DEPENDENT COVERAGE PROGRAM</b>	<b>67</b>
SEC. 12.1: HEALTH REIMBURSEMENT ACCOUNT CREDITS .....	67
(a) EXPENSES ELIGIBLE FOR REIMBURSEMENT UNDER YOUR FLEXIBLE DEPENDENT COVERAGE PROGRAM .....	67
(b) EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT .....	69
SEC. 12.2: REIMBURSEMENT PROCEDURES .....	70
<b>PART 13: HOW TO FILE A CLAIM</b>	<b>72</b>
SEC. 13.1: CLAIMS FOR MEDICAL BENEFITS .....	72
SEC. 13.2: CLAIMS FOR WEEKLY ACCIDENT AND SICKNESS BENEFITS .....	72
SEC. 13.3: CLAIMS FOR TOTAL AND PERMANENT DISABILITY BENEFITS .....	72
SEC. 13.4: CLAIMS FOR PRESCRIPTION DRUG BENEFITS .....	72
SEC. 13.5: CLAIMS FOR DENTAL BENEFITS .....	73
SEC. 13.6: CLAIMS FOR VISION BENEFITS .....	73
SEC. 13.7: CLAIMS FOR ACTIVE DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT, AND RETIREE DEATH BENEFIT PROGRAM BENEFITS .....	73
SEC. 13.8: CLAIM RECEIPT DEADLINE .....	73
<b>PART 14: IF YOUR CLAIM FOR BENEFITS IS DENIED - APPEAL PROCEDURE</b>	<b>74</b>
<b>PART 15: RIGHT TO RECOVERY</b>	<b>76</b>
<b>PART 16: ASSIGNMENT, SUBROGATION AND REIMBURSEMENT</b>	<b>77</b>
<b>PART 17: COORDINATION OF BENEFITS</b>	<b>79</b>
SEC. 17.1: COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS .....	79
SEC. 17.2: COORDINATION WITH MEDICARE .....	80
SEC. 17.3: RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION .....	80
<b>PART 18: NON-ALIENATION OF BENEFITS</b>	<b>81</b>

<b>PART 19: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT</b>	<b>82</b>
<b>SEC. 19.1: NOTICE OF PRIVACY PRACTICES</b> .....	<b>82</b>
<b>(a) USE AND DISCLOSURE OF HEALTH INFORMATION</b> .....	<b>82</b>
To Make or Obtain Payment .....	82
To Conduct Health Care Operations .....	82
For Treatment Alternatives .....	83
For Distribution of Health Related Benefits and Services .....	83
For Disclosure to Plan Sponsor .....	83
Where Required or Permitted by Law .....	83
<b>(b) AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION</b> .....	<b>83</b>
<b>(c) YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION</b> .....	<b>83</b>
Right to Request Restrictions .....	83
Right to Receive Confidential Communications .....	84
Right to Inspect and Copy Your Health Information .....	84
Right to Amend Your Health Information .....	84
Right to an Accounting .....	84
Right to a Paper Copy of this Notice.....	84
<b>(d) DUTIES OF MCTWF</b> .....	<b>85</b>
<b>(e) TO CONTACT MCTWF WITH QUESTIONS</b> .....	<b>85</b>
<b>PART 20: YOUR RIGHTS UNDER ERISA</b>	<b>86</b>
<b>SEC. 20.1: RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS</b> .....	<b>86</b>
<b>SEC. 20.2: CONTINUE GROUP HEALTH PLAN COVERAGE</b> .....	<b>86</b>
<b>SEC. 20.3: PRUDENT ACTIONS BY PLAN FIDUCIARIES</b> .....	<b>86</b>
<b>SEC. 20.4: ENFORCE YOUR RIGHTS</b> .....	<b>87</b>
<b>SEC. 20.5: ASSISTANCE WITH YOUR QUESTIONS</b> .....	<b>87</b>
<b>PART 21: PLAN ADMINISTRATION INFORMATION</b>	<b>88</b>
<b>SEC. 21.1: NAME AND ADDRESS OF PLAN</b> .....	<b>88</b>
<b>SEC. 21.2: PLAN SPONSOR</b> .....	<b>88</b>
<b>SEC. 21.3: EMPLOYER IDENTIFICATION NUMBER (EIN)</b> .....	<b>88</b>
<b>SEC. 21.4: PLAN NUMBER</b> .....	<b>88</b>
<b>SEC. 21.5: TYPE OF WELFARE PLAN</b> .....	<b>88</b>
<b>SEC. 21.6: TYPE OF PLAN ADMINISTRATION</b> .....	<b>88</b>
<b>SEC. 21.7: PLAN ADMINISTRATOR</b> .....	<b>88</b>
<b>SEC. 21.8: PLAN TRUSTEES</b> .....	<b>89</b>

**SEC. 21.9: COLLECTIVE BARGAINING AGREEMENTS .....89**  
**SEC. 21.10: SOURCES OF CONTRIBUTIONS TO YOUR PLAN.....89**  
**SEC. 21.11: FUNDING .....89**  
**SEC. 21.12: PLAN YEAR .....89**  
**SEC. 21.13: AGENT FOR SERVICE OF LEGAL PROCESS .....89**  
**SEC. 21.14: ADMINISTRATIVE SERVICES .....89**  
**(a) EMPLOYMENT RIGHTS NOT GUARANTEED .....90**  
**(b) PLAN AMENDMENT OR TERMINATION .....90**  
**(c) MCTWF TERMINATION .....90**

**PART 22: IMPORTANT DEFINITIONS ..... 91**

## PART 1: GENERAL EXCLUSIONS AND LIMITATIONS

The following are not Covered under your MCTWF Plan:

- injury or Illness arising in the course of employment that is Covered under any workers' compensation or occupational disease law or other state law or other insurance, except in the case where the Employer or workers' compensation carrier reverses its initial determination and denies further benefits;
- expenses incurred for care of injuries or Illnesses due to war or war-related acts;
- any expenses you incur that you are not legally required to pay;
- based upon Michigan's No-Fault automobile insurance laws providing for comprehensive health care benefits to any person(s) suffering an injury or Illness as a result of an automobile Accident in Michigan or those who are covered by Michigan No-Fault automobile insurance and suffer an injury or Illness in an out-of-state (but within the United States, its territories and possessions or in Canada) automobile-related Accident, no medical benefits will be paid by your MCTWF Plan for auto-related injuries or Illnesses (this does not include motorcycle Accidents not involving an automobile);
- if you reside outside the State of Michigan and suffer an injury or Illness resulting from an automobile Accident outside the state of Michigan you will not be eligible for any medical benefits under any MCTWF Plan (this does not include motorcycle Accidents not involving an automobile) if such benefits are payable or required to be covered under other insurance or applicable state law. If your auto-related injury or Illness is not covered under Michigan's No-Fault automobile insurance laws or other similar No-Fault state laws, MCTWF will provide benefits pursuant to a signed MCTWF *Assignment, Subrogation and Reimbursement Agreement*, contingent upon the submission of proof that benefits have been exhausted through the automobile carrier;
- in such cases where other medical coverage is available, no MCTWF Plan benefits will be paid for automobile-related injury or Illness on your behalf if you are the operator or occupant of a rental vehicle;
- any surgery or medical care or service furnished by any facility contracted for or operated by the United States Government or by any other governmental unit for medical care or treatment unless a charge is made that you are legally required to pay;
- charges for completing claim forms or missed appointments;
- claims made for benefits beyond fifteen months from the date the expense was incurred (i.e., the date services were rendered);
- injury or Illness suffered while in the armed forces of the United States;
- in such case where a Retiree Medical Program Participant and/or his Spouse, or a COBRA beneficiary becomes eligible for Medicare coverage, no MCTWF Plan benefits will be paid; and
- repair or replacement made necessary because of loss or damage due to misuse, mistreatment or theft.

# PART 2: ELIGIBILITY

## SEC. 2.1: ACTIVE BENEFIT PLANS

### 2.1(a) ENROLLING IN THE PLAN

Prior to your becoming eligible for Active Program benefits, you will receive an MCTWF *Enrollment Card* with your new hire packet of information. You must complete the front and back of the card, sign the back and return it to MCTWF.

You must complete this card in an accurate and timely manner. If MCTWF receives a claim for you or one of your Dependents, processing your claim and reimbursing your expenses will be delayed or your benefits will be suspended if you have not -

- completed the *Enrollment Card*;
- provided accurate information; and
- notified MCTWF of changes in the information you provided.

Below is a list of required documentation and each familial situation they pertain to:

<b>Dependents on your Enrollment Card:</b>	<b>The situation is due to:</b>	<b>Documentation Required:</b>
Spouse with a different last name than Participant	Wife kept maiden name.	• Marriage Certificate
Natural children with a different last name than the Participant	Parents were never married.	• Birth Certificate; or • Certified copy of Affidavit of Parentage (sometimes referred to as paternity acknowledgement); or • Order of Filiation and Support; or • National Medical Support Notice.
Children not listed on original enrollment card	Newborn or Dependent children are not previously enrolled.	• Birth Certificate; or • Certified copy of Affidavit or Parentage (sometimes referred to as paternity acknowledgement); or • Order of Filiation and Support; or • National Medical Support Notice.
Step children	Participant marries and new Spouse has children from previous relationship.	• Birth Certificate; and • When applicable, portion of the finalized Judgment of Divorce, that includes names of the parties, names of children, who has custody and who has financial responsibility for the children's health care expenses; and • Marriage Certificate to the natural parent of the stepchild.
Adopted children	Adoption is in process.	• Order Placing Children After Consent; or • Order of Adoption.
Children ages 19 to 24 years	Dependent is a full-time student enrolled in a degree or certification program offered by an accredited academic institution or vocational school.	• MCTWF <i>Full-Time Student Eligibility Verification Form</i> completed in its entirety (see page 6, Sec. 2.1(d), Covering Your Dependents).

<b>Dependents on your Enrollment Card:</b>	<b>The situation is due to:</b>	<b>Documentation Required:</b>
Children ages 19 and greater not full-time student	Dependent is totally and permanently disabled.	<ul style="list-style-type: none"> <li>Statement from physician, psychologist or psychiatrist documenting the disability (see page 6, Sec. 2.1(d), Covering Your Dependents).</li> </ul>

## 2.1(b) UPDATING ENROLLMENT INFORMATION

### Family Status Changes

Changes in family status are marriage, divorce, death, birth, placement for adoption, adoption, new Dependent child status due to Total and Permanent Disability, cessation of Dependent child status or a change in your Spouse's primary group health, dental or vision insurance carrier. You must notify MCTWF immediately when you have a "change in family status" by completing and returning MCTWF's *Change in Family Status Form*, along with the appropriate documentation (see page 2, Sec. 2.1(a), for the list of required documentation). Upon receipt of notification and the required documentation, coverage will either be provided retroactive to the date of the event in the case of marriage, birth, placement for adoption, adoption, or terminated in the case of divorce, death and cessation of Dependent child status at midnight of the day of the event.

If your Employer contributes under a "tiered" contribution rate structure, you must notify MCTWF of a change in family status event within 60 Days following the date of the event. Receipt of such timely notification will allow retroactive coverage to the date of the change. Failure to comply with this 60 Day requirement will, for new Dependents, eliminate retro activity and therefore coverage will only be prospective, from the date of MCTWF's receipt of notification.

Coverage for your Dependent terminates upon the loss of Dependent status as a result of divorce, death, cessation of Dependent child status, or early Medicare eligibility for Retiree Medical Program Participants. In the event of a divorce, Spouse eligibility continues through midnight of the date of divorce. Your failure to notify MCTWF of the loss of a Dependent status at the earliest possible date will result in the pursuit of recovery from you for Dependent claims paid after the loss of the Dependent status, and may result in the unavailability of COBRA continuation coverage.

### Participant Information Changes

In order for MCTWF to communicate with you and provide you with information about your MCTWF Plan of benefits, having a record of your current address, telephone number and email address is necessary. To provide this information you must notify MCTWF in writing by completing an MCTWF *Contact Update Form*.

Both the *Change in Family Status Form* and the *Contact Update Form* are available on the Forms page of MCTWF's website.

### Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order providing for child support, usually resulting from a divorce or legal separation that -

- designates one parent to pay for a child's health Plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies; and
- identifies each health care Plan to which the QMCSO applies.

If a court has issued an order with respect to health care coverage for any of your Dependent children, MCTWF will determine if the court order is a QMCSO as defined by federal law. MCTWF's determination will be binding on you, the other parent, the child and anyone acting on the child's behalf.

The QMCSO may not require that your MCTWF Plan provide any benefits that are not otherwise provided. However, if you are a Participant in the Plan, the QMCSO may require your MCTWF Plan to provide coverage for your Dependent child and to accept Contributions for their coverage from a parent who is not an MCTWF Plan Participant. Your MCTWF Plan will accept a Special Enrollment of the Dependent child specified by the QMCSO from either you or the custodial parent. Coverage of the Dependent child will start on the day the MCTWF *Enrollment Card* is received by your MCTWF Plan. Coverage is subject to all terms and provisions of your MCTWF Plan, including the limits on selection of provider and requirements for prior authorization of services, as permitted by applicable law.

If you are eligible, but not Covered by your MCTWF Plan at the time the QMCSO is received and the QMCSO orders you to provide coverage for your Dependent child, your MCTWF Plan will accept a Special Enrollment for you and the Dependent child specified by the QMCSO. Coverage will start on the day the *Enrollment Card* is received by your MCTWF Plan, and will be subject to all terms and provisions of your MCTWF Plan as permitted by applicable law.

Coverage of a Dependent child under a QMCSO will end when your coverage ends for any reason. The Dependent child may have a right to elect COBRA continuation coverage.

The QMCSO may also require your MCTWF Plan to pay benefits either directly to the health care provider who rendered the services or to the child's custodial parent. If coverage of the Dependent child is actually provided by your MCTWF Plan, and if the Plan Administrator determines that the QMCSO is valid, your MCTWF Plan benefits will be paid as required by that QMCSO.

### 2.1(c) ELIGIBILITY FOR COVERAGE

Once your eligibility has been established, pursuant to weekly or hourly/daily Contributions as described below, you will receive an MCTWF Networks Card and a Blue Cross ID Card. If you have dependents, you will receive two of each card both in the name of the Participant. To ensure your full coverage, please present your MCTWF Networks Card and your Blue Cross ID card when receiving services. The cards will evidence your coverage, including restrictions, and provide billing instructions. You may verify your eligibility by contacting MCTWF's Customer Communications Department.

## **Eligibility for Coverage Based on Weekly Contributions**

If you are a full time Employee on the date your Employer starts participating in MCTWF or if you were covered by another group health plan jointly or solely administered by a Teamsters Local Union immediately preceding commencement of participation in MCTWF, you are eligible for coverage under your MCTWF Plan on the date your Employer starts participating. Otherwise, eligibility for Employers who are contributing for on a weekly basis is established upon receipt of nine weeks of Employer Contributions on your behalf during any consecutive 13 week period. Coverage is retroactive to the first day (Sunday) of the ninth week.

Other circumstances that may affect your participation in your MCTWF Plan are -

- If you are on layoff the day your benefits would normally become effective and you return to Active employment within 26 weeks, your coverage will begin upon your return. However, if your eligibility for coverage ceases as a result of layoff, eligibility will resume upon resumption of Covered employment with that Employer so long as your seniority has been maintained (except where seniority is not provided for in your Collective Bargaining Agreement).
- If you are on layoff the day your benefits would normally become effective and you return to work in 26 weeks or more, you must reestablish eligibility according to the 9 out of 13 initial eligibility rule.

You are Covered for benefits under an MCTWF Plan only for weeks for which your Employer has made Contributions to MCTWF on your behalf, except as you may be entitled to extended coverage through application of benefit bank weeks (see page 9, Sec. 2.1(h), Benefit Bank Weeks) or due to a non-work related Disability (see page 47, Sec. 4.2, Continuation of Benefit Eligibility) or due to your COBRA continuation coverage participation (see page 14, Sec. 2.2, COBRA Continuation Coverage). You must have a contribution reported for the week services are received to be eligible for benefits.

## **Eligibility for Coverage Based on Hourly/Daily Contributions**

Eligibility is established in calendar month units based upon either hourly or daily Contributions made on your behalf for work in the second month preceding the month for which eligibility is being determined. To establish eligibility, Contributions must be equal or exceed the monthly contribution cost of the MCTWF Plan. The minimum number of contributable hours or Days required is a function of the cost of the benefit Plan and the hourly or daily contribution rate. Excess Contributions are stored in the Dollars Bank and can be used to supplement monthly Contributions that fall short of the minimum. Furthermore -

- If you are currently eligible for MCTWF benefits based upon weekly Contributions made (and benefit bank weeks applied) on your behalf, MCTWF will convert weekly Contributions made (and benefit bank weeks applied) for the two calendar months prior to the effective date of the change to hourly or daily Contributions to create immediate eligibility. Remaining benefit bank weeks will be available to you only upon future reestablishment of participation pursuant to weekly Contributions.
- If you are not currently eligible for MCTWF benefits, coverage will begin on the first day of the second month following the month in which the minimum number of required hours or Days is contributed by the Employer. The minimum number of hours or Days required may be established during two consecutive months if necessary.

- Once initial eligibility is established it is maintained from month to month if the minimum number of required hours or Days is contributed by the Employer. Excess hours or Days, i.e., those in excess of the minimum number of required hours for a four week month and those in excess of the minimum number of required hours or Days for a five week month, are converted to a Dollars Bank, using the then current hourly or daily contribution rate. The Dollars Bank is used to supplement succeeding months in which Employer Contributions fall below the minimum number of required hours or Days, by reconverting dollars to hours or Days using the then current hourly or daily contribution rate.
- The Dollars Bank is also used to extend eligibility (in full monthly units only), during months of non-payment by the Employer, e.g., layoff, personal leave, voluntary or involuntary terminations, etc. The Dollars Bank may not be used for any other purpose or cashed out.
- When the Dollars Bank is insufficient to establish a full month's eligibility, self-Contributions at the Employer rate may be made by you to supplement the Dollars Bank. Self-Contributions must be made within 15 Days of the date of MCTWF's invoice. Failure to supplement will result in loss of coverage and will freeze use of the Dollars Bank until receipt of Employer contributions.
- If the contribution shortage is not supplemented by you at the Employer contribution rate, you will be offered COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage).
- MCTWF will issue you a monthly account statement reflecting the most recent Contributions made on your behalf, the period for which eligibility, if any, has been established, and your current Dollars Bank balance.

### **2.1(d) COVERING YOUR DEPENDENTS**

MCTWF Plan coverage is available for certain family members. They become Covered by your MCTWF Plan when your eligibility for coverage begins, or if later, on the date they become Dependents as defined below (for example, on the date of your marriage or child's birth, etc.). Dependent coverage continues until the earlier of your loss of eligibility or your Dependent's loss of Dependent status. If your Dependent is confined to a Hospital on the day she becomes eligible for your MCTWF Plan benefits, her prior health Plan remains responsible for charges in connection with that confinement.

Your Dependents are -

- your Spouse;
- your unmarried natural or step child, or child who has been placed with you for adoption, or whom you have adopted, through the end of his 19th birthday month;
- your unmarried natural or step child, or child who has been placed with you for adoption, or whom you have adopted, age 19 through the end of his 24th birthday month who was Covered as a full-time student (as reflected by an MCTWF *Full-Time Student Eligibility Verification Form*) on the date he graduated from high school and who demonstrates (through a letter from an accredited academic institution or an accredited vocational school) his acceptance for enrollment for the subsequent school term as a full-time student;

- your unmarried natural or step child, or child who has been placed with you for adoption, or whom you have adopted, age 19 through the end of his 24th birthday month and who is a full-time, post-high school student, evidence of which is reflected by an MCTWF *Full-Time Student Eligibility Verification Form* submitted to MCTWF after the drop deadline date for the first semester and each successive semester (but no later than the first Saturday in November for the Fall semester and by the first Saturday in March for the Winter/Spring semester). If the completed form is received after the above dates, coverage will be provided prospectively only, commencing the first Sunday following receipt thereof.

To meet this requirement for post-high school coverage, the student must be enrolled full-time in a degree or certification program offered by an accredited academic or vocational school. A non-accredited school is acceptable if that school provides written documentation from a minimum of three accredited schools that its credits and/or degrees are accepted by them. This documentation will not be sought by MCTWF. The student bears the responsibility of obtaining and providing it to MCTWF.

To receive uninterrupted extended coverage beyond the college/university graduation date, a letter of acceptance and an MCTWF *Affidavit of Enrollment in Graduate School* attesting to the student's intention to attend a full-time program at the graduate school and stating the school's minimum requirement for full-time status is required. For the first semester and each semester thereafter, a *Full-Time Student Eligibility Verification Form* must be submitted to MCTWF immediately following the graduate school's drop deadline date for the first semester and each successive semester (but no later than the first Saturday in November for the Fall semester and by the first Saturday in March for the Winter/Spring semester). If the completed form is received after the above dates, coverage will be provided prospectively only, commencing the first Sunday following receipt thereof.

If your full-time student child between the ages of 19 and 24 who is Covered under your MCTWF Plan, takes a Medically Necessary leave of absence from school or a Medically Necessary reduction in credits down to part-time student status, coverage for that child will be extended for up to one year, or until coverage otherwise would terminate under your MCTWF Plan, if all of the following conditions are met: (1) your child is suffering from a serious illness or injury at the time of the Medically Necessary leave of absence or reduction to part-time status; (2) your child's Physician provides written certification that your child indeed is suffering from a serious medical illness or injury that necessitates the leave of absence or change in enrollment status; and (3) your child otherwise would have lost coverage under your MCTWF Plan were it not for this extension; and

- your unmarried natural or step child, or child who has been placed with you for adoption, or whom you have adopted, regardless of age, who has been determined by a Physician, psychologist or psychiatrist to be Totally and Permanently Disabled. If the disabled child is age 19 or greater and the Disability began before the child was Covered under an MCTWF Plan, the Participant must present adequate evidence that the child was covered under the health Plan that immediately preceded MCTWF coverage.

If your step child is Covered as a Dependent and your Spouse dies, MCTWF will provide temporary, contingent coverage to that child for 60 Days. If within that time period you provide documentation of your primary custodial responsibility and primary financial support of the child, MCTWF will extend the temporary coverage to that child for up to one year (including the initial 60 Days) to allow time for legal adoption or for you to obtain other insurance for the child. If you fail to provide the required documentation within the 60 day period, coverage will be retroactively terminated to the first day of that period. If proof of adoption is not received within the one year period, coverage for the child will terminate at the end of the period.

If, as a new Participant, you have legal guardianship of a child who was covered under your immediately preceding health Plan/insurance policy, MCTWF will provide temporary coverage to that child for up to one year to allow time for legal adoption of the child or for you to obtain other insurance for the child. If proof of adoption is not received within the one year period, coverage for the child will terminate at the end of the period.

### **2.1(e) LOSS OF ELIGIBILITY**

As a general rule, you will lose eligibility for benefits under your MCTWF Plan, under any of the following circumstances:

- your employment with a Contributing Employer ends;
- your Employer stops making Contributions to MCTWF on your behalf;
- you stop making self-Contributions;
- your death;
- your Employer no longer participates with MCTWF; or
- the Trustees of MCTWF change, amend or terminate your MCTWF Plan.

Notwithstanding the general rule, your eligibility for benefits may continue if you -

- are eligible for benefit bank weeks;
- are eligible to receive weekly accident and sickness benefits;
- are eligible to purchase COBRA continuation coverage and you make the required payments on time; or
- are eligible for specified periods for leaves of absence under the Family and Medical Leave Act and under the Uniformed Services Employment and Reemployment Rights Act.

Please refer to these sections of your SPD Booklet to determine whether they constitute an exception to one or more of the circumstances described by the general rule.

### **2.1(f) IF YOUR EMPLOYMENT ENDS**

This information will help you understand your benefit status if your employment with a Contributing Employer ends.

#### **Termination**

If you voluntarily end your employment or are discharged and -

- your Employer contributes on a weekly basis, your coverage will end at midnight on Saturday of the last week for which your Employer last makes Contributions to MCTWF on your behalf; or
- your Employer contributes on an hourly or daily basis, your coverage will end on the last day of the month for which Contributions met the minimum requirement for monthly coverage.

When your coverage ends you may be eligible to purchase COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage).

## **Layoff**

If you are laid off and your Employer ceases making Contributions to MCTWF on your behalf, your medical and prescription drug benefits will remain in effect for as long as you have remaining benefit bank weeks if your MCTWF Plan provides benefit bank weeks. When your benefit bank weeks run out, you may be eligible to purchase COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage).

### **2.1(g) IF YOUR EMPLOYER WITHDRAWS FROM MCTWF PARTICIPATION**

If your Employer ceases participation in MCTWF as the result of collective bargaining or in the event of decertification or withdrawal of Local Union representation, eligibility for all Active Employee benefits ceases (including weekly accident and sickness benefits) as of the effective date of such withdrawal, decertification or Local Union disclaimer of representation, and in any such instance, all unused benefit bank weeks are forfeited. COBRA continuation coverage is not available to purchase, and those already making self-payments under COBRA continuation coverage will no longer be accepted. However, if your Employer's Contributions for the month fail to satisfy the minimum requirement for coverage, you may self-contribute the additional sum necessary to satisfy the requirement for that month. If you are already enrolled in the Retiree Medical Program or receiving the total and permanent disability benefit or the extended disability benefit, those benefits will remain in effect according to the eligibility rules listed in this SPD Booklet.

### **2.1(h) BENEFIT BANK WEEKS**

#### **Using Your Benefit Bank Weeks**

You should refer to your Schedule of Benefits to determine whether you are eligible for this benefit and if so, the number of benefit bank weeks available and the defined period in which the benefit bank weeks are available. In the event that your Employer does not make Contributions to MCTWF on your behalf because you are -

- sick;
- laid off;
- on personal leave;
- on military leave;
- out due to sanctioned strike or lockout;
- transferred to another Contributing Employer (to cover the probationary period in the event you were to quit employment with Employer A to go to work for Employer B); or
- retiring.

You will be provided with continued medical and prescription drug coverage, up to the number of benefit bank weeks that you have remaining.

If benefit bank weeks are available to you and you are an Employee of a newly Participating Employer, you will become eligible for benefit bank weeks once your Employer has made Contributions on your behalf for 12 consecutive (or 13 out of 17) weeks of Active employment.

If you were in the process of using your benefit bank weeks before the date on which the defined period of benefit bank weeks availability expires, you are allowed to exhaust your remaining benefit bank weeks. When you return to Active employment after the new benefit bank week defined period commences, upon your reestablishment of eligibility, you will receive the number of benefit bank weeks specified in your Schedule of Benefits for the new defined period.

Benefit bank weeks may be used to continue your MCTWF Plan's medical and prescription drug benefits, however, no vision, dental, weekly accident and sickness, total and permanent disability, or death benefits will be available to cover such services or events when incurred during benefit bank weeks.

#### **You Are Not Eligible for Benefit Bank Weeks -**

- if your MCTWF Plan does not provide benefit bank week coverage; or
- if your employment is terminated (voluntarily or involuntarily) or suspended, except in the event that the termination or suspension is being formally grieved. Upon receipt of written verification of the grievance from the Local Union, together with a copy of the grievance, MCTWF will apply any remaining benefit bank weeks retroactively to the last coverage date.

#### **However -**

If you are subject to workplace alcohol and drug testing, and you are terminated because of a positive test result, you will be eligible for retroactive use of your available benefit bank weeks if -

- you submit to MCTWF documentation of your completion of an approved course of evaluation/rehabilitation by MCTWF's behavioral healthcare program; and
- you return to work with Employer Contributions on your behalf.

### **2.1(i) STRIKE OR LOCKOUT**

If you are not working due to a strike or lockout (i.e., temporary work stoppage) MCTWF will continue to provide benefits, subject to the following conditions:

- the strike must be sanctioned by the International Brotherhood of Teamsters (IBT) or the locked out employees must be supported by the IBT, as evidenced by payment of IBT strike wages;
- MCTWF must receive written confirmation of strike sanctioning or support from the IBT which must include the inception and termination dates, the name of the Employer, and a list of affected Participants, along with other necessary information, from your Local Union;
- coverage will not be provided if you are on leave of absence, sick leave, layoff, or have been terminated;
- your Employer must not be more than 30 Days delinquent in making required Contributions to MCTWF at the commencement of the temporary work stoppage;
- your unused benefit bank weeks will be applied immediately so as to avoid a lapse in your medical and prescription drug benefits. After all your benefit bank weeks have been exhausted, full coverage will continue during the temporary work stoppage for a maximum of eight weeks, subject to your ongoing compliance with the Local Union's requirements for strike duty. Alternatively, you may exercise your right to elect COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage) since the temporary work stoppage is a COBRA qualifying event;

- during the temporary work stoppage, non-bargaining unit employees will receive a maximum of seven weeks extended coverage, contingent on the Employer's payment of advance Contributions for that period; and
- Teamster Participants who cross the picket line during a sanctioned strike or lockout will lose eligibility for benefits under their MCTWF Plan and MCTWF will not accept Contributions on their behalf for work performed during that temporary work stoppage.

If you are actively employed but have not yet established MCTWF eligibility at the time of the temporary work stoppage, all or a portion of the extended benefit period will be applied to establishing initial eligibility for MCTWF benefits.

## **2.1(j) LEAVES OF ABSENCE**

### **Family and Medical Leaves**

Under the Family and Medical Leave Act of 1993 (FMLA), you may qualify to take up to 12 weeks of unpaid leave or special military leave entitlement for up to 26 weeks during a single 12-month period.

For those Employers to whom the FMLA applies, Basic Leave Entitlement is available -

- for your own serious Illness or incapacity due to pregnancy, prenatal medical care or child birth;
- to care for your newborn child or newly adopted child; or
- to care for your seriously ill Spouse, parent or child.

For those Employers to whom the FMLA applies, Military Family Leave Entitlement is available -

- to Participants with a Spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation to address certain qualifying exigencies which may include attending certain military events, arranging for alternate childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings; or
- to care for a covered servicemember who has a serious injury or Illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary Disability retired list.

If the FMLA applies to your Employer, it requires your Employer to maintain your health coverage for the length of your leave for up to 12 weeks, as if you were actively at work. The FMLA also states that if you take a family or medical leave, you cannot lose any benefits accrued before the leave.

If your Employer grants you a family or medical leave in accordance with the FMLA, and continues to make the required Contributions to MCTWF for your coverage, you will maintain your current eligibility status during your leave. You should contact your Employer for information regarding your eligibility for leave under the FMLA.

If your Employer grants you further leave beyond the permissible FMLA period but stops making Contributions to MCTWF on your behalf, and if you have available benefit bank weeks, you have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see page 14, Sec. 2.2, COBRA Continuation Coverage).

## **Military Leave**

If you are on leave because of military service -

- for less than 31 Days, coverage during that leave period will continue at no cost to you; and
- after 30 Days, if you have available benefit bank weeks, you have the option of when to apply them by submitting to MCTWF written instructions prior to commencement of military leave which will delay the application until discharge from military duty. Otherwise, you may be eligible to continue your medical coverage at your own expense for up to 18 Months (see page 14, Sec. 2.2, COBRA Continuation Coverage).

## **Other Leaves**

If you take any other leave of absence and your Employer stops making Contributions to MCTWF on your behalf, and if you have available benefit bank weeks, you have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see page 14, Sec. 2.2, COBRA Continuation Coverage).

## **2.1(k) INJURY OR ILLNESS**

If you are unable to work due to injury or Illness and your Employer is not obligated to make further Contributions to MCTWF on your behalf, your medical and prescription drug benefits will remain in effect for as long as you have benefit bank weeks remaining. However, if you are receiving weekly accident and sickness benefits from your MCTWF Plan, your coverage will continue for as long as that benefit is being paid (see page 47, Sec. 4.2, Continuation of Benefit Eligibility), after which remaining benefit bank weeks are applied. When your benefit bank weeks run out, you may be eligible to purchase COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage).

## **2.1(i) REINSTATEMENT OF COVERAGE**

If your coverage ends because you are no longer working for a Contributing Employer and you return to work for a Contributing Employer within 26 weeks of your last date of coverage, you will again be Covered by your MCTWF Plan as of the first day (Sunday) of the week for which Contributions resume on your behalf. If you do not return to work within 26 weeks you will have to reestablish your eligibility (see page 4, Sec. 2.1(c), Eligibility for Coverage). However, if you are laid off and are eligible for coverage at the time of layoff, regardless of the duration of layoff, you will again be Covered by your MCTWF Plan as of the first day of the week for which Contributions resume on your behalf, so long as you have retained your seniority rights. If you are laid off by an Employer in an industry that provides no seniority recall rights, you will be reinstated upon your return to work with that Employer, if you return to work within 18 Months of the last date of coverage following the layoff.

If your MCTWF Plan coverage ends because you begin active military service, the Uniformed Services Employment and Reemployment Rights Act (USERRA) gives you rights to reinstatement of coverage under certain circumstances when you complete your period of military service. Your rights to reinstatement of coverage under your MCTWF Plan will be interpreted in accordance with USERRA.

To be eligible for reinstatement -

- the cumulative length of your absences from employment with your former Contributing Employer due to military service must be no greater than five Years; and
- you must not have received a dishonorable or bad conduct discharge or separation from service under other than honorable conditions.

If your coverage ends because you begin active military service and your period of military service is more than 30 Days but less than 181 Days, your coverage will be reinstated if you apply for reemployment with your former Contributing Employer within 14 Days after completion of the period of military service.

If, because of circumstances beyond your control, submitting an application within the 14-day period is impossible or unreasonable, the application must be submitted on the next first full calendar day when submitting the application becomes possible.

If your coverage ends because you enter or are drafted into active military service for more than 180 Days, your coverage will be reinstated if you return to Covered employment within 26 weeks following military service discharge. This deadline will be extended up to two Years if you are hospitalized or convalescing because of a service-related injury or illness. Coverage for you will be reinstated on the day you return to work, provided that Contributions have resumed on your behalf.

### **2.1(m) DEATH**

If you die, your Dependents' medical and prescription drug benefits will continue for as long as you have benefit bank weeks remaining. When your benefit bank weeks run out, your Dependents may be eligible to purchase COBRA continuation coverage (see page 14, Sec. 2.2, COBRA Continuation Coverage).

### **2.1(n) FLEXIBLE DEPENDENT COVERAGE PROGRAM**

To be eligible to participate in the Flexible Dependent Coverage Program, the following conditions must be met:

- you must have Dependents unless you enrolled in the Program by December 31, 2006 and remained continuously enrolled and eligible in the Program thereafter ("grandfathered") by virtue of the payment on your behalf of composite rate Contributions by your Employer;
- all of your Dependents must have coverage under another group health plan, and you must provide proof to MCTWF of the other coverage; and
- you must complete and submit an MCTWF *Flexible Dependent Coverage Program Election Form*.

If you and your Spouse are both Covered under an MCTWF Plan, under which each is a Dependent of the other and you don't have Dependent children, each can participate in the Program.

### **How to Enroll**

You must enroll in accordance with the rules that follow:

- You must enroll beginning in November for the upcoming calendar year if you are enrolling for the first time, by completing, signing and dating the *Flexible Dependent Coverage Program Election Form*, and returning it to MCTWF no later than December 31. If you are a new Participant you must enroll within 30 Days of first becoming eligible under your MCTWF Plan.
- You must submit proof of your Dependent's other group health coverage with the *Flexible Dependent Coverage Program Election Form*.

Claim forms will be sent to you with the notice confirming your enrollment in the Flexible Dependent Coverage Program. Once you have enrolled, your coverage will automatically be renewed each year until you send written notification to MCTWF that you are discontinuing participation in the Program.

### **Change in Family Status**

You must notify MCTWF immediately upon a change in family status to ensure proper handling of your claims if -

- you add a Dependent as a result of marriage, birth or adoption and that Dependent is not covered under another group health plan, your participation will cease in the Flexible Dependent Coverage Program; or
- your Dependents were covered under another group health plan and lose that coverage, you may stop participating in Flexible Dependent Coverage Program at that time. You must provide proof of the loss of coverage.

## **SEC. 2.2: COBRA CONTINUATION COVERAGE**

Under certain circumstances, you will have the opportunity to continue your health care coverage after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA, provides you a right to continuation of coverage under your MCTWF Plan.

The COBRA continuation coverage available to you will be identical to the applicable medical, prescription drug, dental and vision coverage you had before your coverage ended. You will be required to pay the full cost for the coverage you continue, plus an administrative charge, according to the applicable single or family rate. If, during a period of COBRA continuation coverage, you marry, have a newborn child, adopt a child, or otherwise add a Dependent, that Dependent may be added to the coverage for the balance of the period of COBRA continuation coverage. Otherwise, once you elect a COBRA Plan of benefits and coverage tier (single or family) and initial COBRA continuation coverage self contribution has been made, you may not thereafter change your coverage selection under any circumstance. Your payments for COBRA continuation coverage must be made on time or coverage will be terminated.

## **2.2(a) COVERAGE ENTITLEMENT PERIOD**

COBRA continuation coverage is available for 18 Months, 29 Months and 36 Months based on who the beneficiary is and the nature of the qualifying event resulting in the loss of coverage under the MCTWF Plan.

### **When COBRA Continuation Coverage Continues For Up to 18 Months**

You may elect COBRA continuation coverage for up to 18 Months pursuant to the following qualifying events:

- your termination of employment for reasons other than gross misconduct; or
- your reduction in employment hours.

### **When COBRA Continuation Coverage Continues For Up to 29 Months**

If your employment terminated due to one of the above qualifying events and at the time of the event, or within 60 Days after the event, you are totally disabled, the disabled person, as well as members of the disabled person's family, may elect to continue coverage for an additional 11 months, for a total of 29 months. The cost will be higher for the additional 11 months of coverage. The Disability must be determined by the Social Security Administration.

If you already have COBRA continuation coverage for a period greater than 29 months, no additional extension will be granted because of Disability.

You must notify MCTWF of the determination of Disability by the Social Security Administration within 60 Days after the determination.

If a second qualifying event occurs within the 29 month period, coverage for the affected beneficiary is extended an additional seven months for a total of 36 months.

If the qualifying event is a loss of coverage due to a temporary layoff, MCTWF continuation coverage provides additional coverage beyond COBRA continuation coverage for a maximum of 12 months beyond the COBRA entitlement period for you depending upon the length of your seniority recall period as stated in your Collective Bargaining Agreement. The combination of the COBRA continuation coverage period based on a temporary layoff and the MCTWF continuation coverage period cannot exceed the duration of the recall period. Thus, if the recall period is 24 months and you have exhausted your 18 month COBRA continuation coverage you may purchase MCTWF continuation coverage (the same COBRA package at the then current COBRA rate) for up to six months. If, however, the recall period is less than 18 months (or less than 29 months if COBRA continuation coverage was extended due to Disability), then no MCTWF continuation coverage will be available. Furthermore, MCTWF continuation coverage will be made available only so long as you are able to enforce your seniority recall rights and your Employer remains obligated to contribute to MCTWF. Thus, if your Employer has bargained out of MCTWF, or has ceased covered operations, or no Collective Bargaining Agreement is in effect, or you are permanently disabled, MCTWF continuation coverage will not be offered, or if already commenced, will be curtailed upon notice to you of coverage cessation effective the end of the month following the month in which MCTWF so notifies you.

### **When COBRA Continuation Coverage Continues For Up to 36 Months**

Your Dependents may elect to continue coverage for up to 36 months (in aggregate) if their coverage under your MCTWF Plan ends for any of the following reasons or qualifying events:

- your death;
- your divorce;
- your child's loss of Dependent status under the Plan;
- you become eligible for Medicare; or
- two or more qualifying events.

## **2.2(b) HOW TO ELECT COBRA CONTINUATION COVERAGE**

A COBRA notice is sent to you upon notification to MCTWF of a qualifying event. Election of COBRA continuation coverage must be made no later than 60 Days from the date you are notified of a COBRA qualifying event. If the election is not received within 60 Days, you lose your right to COBRA continuation coverage. Your available benefit bank weeks will automatically be applied to the period immediately following your loss of coverage unless you choose to elect COBRA continuation coverage, in which case you must select one of the following COBRA continuation coverage options:

**Option 1:** Election of COBRA continuation coverage to follow benefit bank week(s). Your remaining benefit bank week(s) will be immediately applied retroactive to the qualifying event date. Thereafter, COBRA continuation coverage will commence and continue, contingent upon timely submission of COBRA continuation coverage self-Contributions.

**Option 2:** Election of COBRA continuation coverage to precede benefit bank week(s). Upon receipt of timely election and COBRA continuation coverage self-Contributions, COBRA continuation coverage will be retroactively applied to immediately follow the qualifying event and will continue until the earlier of your exhaustion of your statutory entitlement period or early cessation due to non timely submission of COBRA continuation coverage self-Contributions. Thereafter, the remaining benefit bank weeks will be applied.

Upon MCTWF's receipt of an MCTWF *COBRA Continuation Coverage Election Form*, a COBRA Invoice will be sent to you and you have 45 Days from the date of the invoice to make the COBRA payment. Once payment has been made, the COBRA election cannot be changed for any reason (except when adding a new Dependent due to marriage, newborn child, or newly adopted child, or otherwise adding a new Dependent). If after you elect COBRA and before initial payment is made and within the COBRA election period, you decide to change your benefit Plan selection or benefit bank week option selection, you will be allowed to do this by completing a new *COBRA Continuation Coverage Election Form*. If, after you elect COBRA and before initial payment is made and within the COBRA election period, you decide to change the coverage tier (e.g. from family coverage to a named beneficiary single coverage), this will be allowed on a prospective basis only, based on the date the new election is received and you will be responsible for the COBRA payment under the initial coverage tier retrospectively and the new coverage tier going forward. COBRA continuation coverage will commence once MCTWF has received the *COBRA Continuation Coverage Election Form* and upon timely receipt of COBRA continuation coverage self-Contributions. The initial Contribution covers the period between the date of your loss of coverage to the date of your election plus any regularly scheduled monthly Contributions due between your election and the end of the 45-day period. After payment of the initial Contribution, payments are due in advance for each month on the last day of the preceding month.

### **2.2(c) MEDICARE ENROLLED INDIVIDUALS ELECTING COBRA CONTINUATION COVERAGE**

Under Federal law, if you are enrolled in Medicare and are age 65 or more, or are enrolled in Medicare based on Disability, and elect COBRA continuation coverage, Medicare is the Primary Plan for coordination of benefit purposes. Your continuation coverage Plan benefits will be limited to those in excess of Medicare Part A and Medicare Part B benefits, up to your continuation coverage Plan limits, regardless of whether you have enrolled in Medicare Part B.

If you are covered by Medicare due to End Stage Renal Disease (ESRD) and elect COBRA continuation coverage, COBRA continuation coverage is primary for up to 30 months (less the period of time during which you received coverage for the disease under the Active MCTWF Plan) from the Medicare eligibility date. After the 30 month period, Medicare is the Primary Plan for coordination of benefit purposes. Your continuation coverage Plan benefits will be limited to those in excess of Medicare Part A and Medicare Part B benefits, up to your continuation coverage Plan limits, regardless of whether you have enrolled in Medicare Part B.

### **2.2(d) NOTIFYING MCTWF OF DEPENDENT COBRA QUALIFYING EVENT**

You are responsible for notifying MCTWF if you divorce, or your child no longer qualifies for Dependent coverage. This must be done within 60 Days of the qualifying event or within 60 Days from the date you receive the election form for COBRA continuation coverage, whichever is later. If you fail to notify MCTWF of your divorce or loss of Dependent status within 60 Days, you will lose the right to COBRA continuation coverage.

You will be given an additional 45 Days from the date you elect COBRA continuation coverage to make any back payment necessary to avoid a gap in coverage. Failure to remit the premium within 45 Days of the payment due date will result in cancellation of all coverage. Payments for subsequent months are due by the last day of the month prior to the month for which coverage is provided. For example, payment for June coverage is due by May 31st.

To help ensure that you do not lose coverage, MCTWF recommends that you notify MCTWF as soon as possible of any events that can cause your coverage to end.

### **2.2(e) LOSS OF COBRA CONTINUATION COVERAGE**

COBRA continuation coverage can terminate prior to the 18/29/36 month time frames for any of the following reasons:

- you become covered under another group health plan. However, coverage may be continued if you have a health problem for which coverage is excluded or limited under the other group health Plan;
- your Employer stops participating in MCTWF and your Employer provides coverage to the Employee group under another health Plan (in that event, the other health Plan will be required to offer COBRA for the remaining period of coverage). However, if you have a health problem for which you are receiving treatment, coverage for that condition will continue until that condition is covered by another Plan or you reach the time limits for COBRA continuation coverage;
- the required Contributions are not paid on time;
- your MCTWF Plan is terminated;
- you become entitled to Medicare after the COBRA election; or
- your coverage has been extended to 29 months and it is determined that you are no longer disabled.

## **2.2(f) CERTIFICATE OF CREDITABLE COVERAGE**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a Certificate of Creditable Coverage to be issued when there is a loss of coverage. The certificate will show how long you were Covered under your MCTWF Plan.

If you lose coverage, MCTWF will send to you, along with an MCTWF *COBRA Continuation Coverage Election Form*, a Certificate of Creditable Coverage. If you become covered under another health Plan, show this certificate to your next Plan Administrator. It may decrease or eliminate any pre-existing condition limitation period under that Plan.

You may also request a Certificate of Creditable Coverage on behalf of any of your Dependents.

An additional certificate will automatically be provided within a reasonable period of time after your COBRA continuation coverage stops. You can request from MCTWF a certificate at any time within the 24-month period after COBRA continuation coverage stops.

Your MCTWF Plan does not have a pre-existing condition exclusion.

## **SEC. 2.3: RETIREE BENEFIT PLANS**

### **2.3(a) RETIREE MEDICAL PROGRAM**

#### **Eligibility for Participation**

Your Retirement Date means the date a Participant ceases to be Covered by MCTWF 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 continuation coverage may extend his Retirement Date until the cessation of such coverage. The following eligibility rules apply to Participants seeking to enroll in MCTWF's Retiree Medical Program (Program):

#### **Participants Age 57 or Older**

- Must have participated in an eligible MCTWF Plan (i.e., one that includes Program benefits) and must have had Contributions made on his behalf (i.e., Contributions to an eligible MCTWF Plan) for at least 40 weeks in each of the five consecutive 52 week periods immediately preceding the Retirement Date, 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 a Participant performed Seasonal Work, eligible 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 pro rata based on the type of work in which the Employee was engaged during the measuring period).
- Must not be eligible for Medicare coverage.
- Must not be engaged in Prohibited Employment (see Definitions, page 91).

#### **Participants Under Age 57**

- Must be age 57 or older to commence participation in the Program (see Automatic Deferrals), with the exception of 30-and-Out Pension Retirees age 50 or older, who meet the eligibility rules for age 57 or older (described above).

#### 30-and-Out Pensioners from a Teamster Pension Fund

- Ages 50 to 56 – Must meet all of the eligibility rules for age 57 or older described above and must provide proof of “30-and-Out” pension, at the time of timely application for Program enrollment.
- Under Age 50 – Must meet all of the eligibility rules for ages 50 to 56 “30-and-Out” pensioners described above, and must defer participation in the Retiree Medical Program until at least age 50.

### **Retiree Supplemental Benefits Rider**

The Retiree Supplemental Benefits Rider (Retiree Rider) supplements the Retiree Medical Program with MCTWF’s hearing, vision and dental Plan 2 benefits at a monthly cost-based Contribution rate, and is available to you at the time of election into the Retiree Medical Program. After the Retiree Rider is elected it may be dropped effective March 31st of any year, following at least one year of Retiree Rider coverage. To drop the Retiree Rider you must notify MCTWF in writing by February 20th of the year you no longer wish to participate. Once the Retiree Rider coverage is dropped, it will not be available to you again.

### **Uniformed Services (Military Leave)**

Uniformed Services credit may count toward satisfying MCTWF participation requirements (i.e., Years of service) for establishing Program eligibility under the five out of five or seven out of 10 year Contribution rules, and toward determining the 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 MCTWF (a Contributing Employer) on his behalf for a MCTWF Plan of benefits that included Program 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”); and
- the Participant must have applied for return to work with an MCTWF Contributing Employer within the following time frames:
  - within 90 Days after completed duty time of more than 180 Days; or
  - within 30 Days after completed duty time of 31 to 180 Days; or
  - within five Days after completed duty time of up to 30 Days.

### **Enrollment and Contributions**

- To enroll in the Program, the retired Participant must complete and submit to MCTWF an *MCTWF Retiree Medical Program Application Form* within 90 Days immediately following the Retirement Date. If the completed application is received beyond the 90 day window period, but within one year of the MCTWF Retirement Date (see Definitions, page 91), the Retiree may enroll and commence coverage for Program benefits as of the first day of the month that falls at least 90 Days after MCTWF’s receipt (and subsequent approval) of the Retiree’s application.

- Retirees approved for Program participation must make self Contributions to MCTWF, as billed, in the amount established by the Trustees. The first self-Contribution must be submitted to MCTWF with the election form. Thereafter, Contributions must be received on or before the 20th day of the month preceding the month for which coverage is provided.\*
- \* Self-Contribution rate amounts are adjusted each April 1st.

#### **COBRA Continuation Coverage Contributions**

- Age 50 or older retiring Participants may choose to make COBRA continuation coverage Contributions to add to his Years of MCTWF service and/or age (which will allow them to contribute at a lower rate).
- Under age 50 retiring Participants may not count COBRA continuation coverage Contributions toward establishing his Retirement Date, with the exception of those with 25 or more Years of MCTWF participation.

#### **Restriction on Program Participation**

The right of retiring Participants to newly enroll in the Program is suspended upon the expiration of his Collective Bargaining Agreement (CBA) and will remain so unless the parties agree to renew participation in MCTWF, retroactive to the prior CBA's expiration date. In such case, the Retiree's right to enroll is retroactively restored.

#### **Eligibility for Deferred Participation in the Program**

##### **Automatic Deferrals**

- “30-and-Out Pension” Retirees who are under age 50 and have completed and timely submitted the *Retiree Medical Program Application Form* and who qualify for Program participation, will be automatically deferred until age 50 or later. The Retiree must notify MCTWF at such time as he wishes to commence participation. The self-Contribution rate will be calculated based upon the age of the Retiree at the commencement of coverage.
- Retiring Participants who are age 50 to 56, who are not 30-and-Out Pension Retirees, and who have completed and timely submitted the *Retiree Medical Program Application Form* and who qualify for Program participation, will be automatically deferred until age 57 or later. The Retiree must notify MCTWF at such time as he wishes to commence participation. The self-Contribution rate will be calculated based upon the age of the Retiree at the commencement of coverage.

##### **Voluntary Deferrals**

- Pre-Enrollment – Retired Participants who have completed and timely submitted the *Retiree Medical Program Application Form*, and are approved for Program participation, may defer participation upon written request. The Retiree must notify MCTWF at such time as he wishes to commence participation. The self-Contribution rate will be calculated based upon the age of the Retiree at the commencement of coverage.
- Post-Enrollment – Retired Participants may defer coverage any number of times after commencement of participation in the Program, upon written request, subject to the requirement that the Retiree must defer participation for no less than 12 months each time. At such time as the deferring Retiree seeks to resume participation in the Program, the self-Contribution rate will be the same rate fixed for the Retiree at the time of deferral.

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 (at least eight weeks if it is with an Employer that contributes to MCTWF). Therefore, the deferring retired Participant may continue participation in the Program by making his monthly Program self-Contribution until eligibility for the new coverage is established.

If by virtue of Active MCTWF participation during the deferral period, the deferring Retiree can newly satisfy the initial eligibility rule of five out of five or seven out of 10 Years of MCTWF participation immediately preceding resumption of Program participation, the Program self-Contribution rate will be recalculated to reflect the additional year(s) of service earned and the age of the retired Participant at the commencement of resumed coverage under the Program.

#### Exceptions to 12-Month Rule

- If the deferral is for the purpose of employment as a bargaining unit member by an Employer that contributes to MCTWF for an MCTWF Plan that includes Program benefits, the 12 month minimum deferral period will be waived.
- If the retired Participant asserts to MCTWF that he is seeking to defer because he has coverage under another group health plan (for example, as a Dependent under his Spouse's Plan), he may return to Program participation at any time thereafter, upon MCTWF's receipt of written documentation from the other group health plan that evidences the loss of coverage.

In the event that your Spouse elects COBRA continuation coverage, her right to participate in the Program as an Extended Retiree Spouse will be deemed deferred (see Covering Your Spouse below).

### **When Your Coverage Begins**

Generally, you are Covered under the Program when your eligibility has been confirmed and you have paid your Retiree self-Contributions for coverage. Once your eligibility has been established, you will receive an MCTWF Networks identification card and a Blue Cross ID Card. Participants with an eligible Spouse will receive two of each card both in the name of the Participant. To ensure your full coverage, please present your MCTWF Networks Card and your Blue Cross ID card when receiving services. The cards will evidence your coverage, including restrictions, and provide billing instructions.

You may verify your eligibility by calling MCTWF's Customer Communications Department.

### **Covering Your Spouse**

If you are Covered under the Program -

- coverage automatically is provided to your Spouse if she is under age 65 and not eligible for Medicare.
- and you reach age 65, your Spouse who is not yet age 65 and not eligible for Medicare may continue coverage under the Program at the same Retiree self-Contribution rate for the earlier of five Years following the date your Program coverage began or until she attains age 65 or is eligible for Medicare.
- and you are eligible for Medicare before age 65 or die prior to reaching age 65, your Spouse may continue coverage under the Program at the same Retiree Contribution rate until the earlier of your 65th birthday, your Spouse's 65th birthday, or the date that she becomes eligible for Medicare.

In the event that the Spouse of a retired Participant exhausts her right to continue participation in the Program at the Program's Retiree self-Contribution rate, the Retiree's Spouse may continue participation in the Program as an Extended Retiree Spouse at cost-based rates (reviewed annually and adjusted each fiscal year by the Trustees), until she reaches age 65 or, if earlier, becomes eligible for Medicare.

### **Termination of Retiree Medical Program Eligibility**

You and your eligible Spouse may lose benefit coverage under the Program if you or your Spouse do not make the required Contributions under the Program within the timeframe permitted or if the Trustees of MCTWF change, amend or terminate your MCTWF Plan.

Your Program coverage will end on the first of the following dates:

- the date you reach age 65;
- the date you first become eligible for Medicare coverage, whether or not you enroll in Medicare coverage. However, if you or your Spouse's Medicare eligibility is due to End Stage Renal Disease (ESRD), federal law requires that MCTWF coverage remain primary to Medicare for 30 months, starting with the first month you became eligible to receive Medicare. Upon expiration of the 30-month period, MCTWF coverage will cease for that individual;
- the date of your death;
- the date you become eligible for coverage under an MCTWF Plan as an Active Employee;
- the date you engage in Prohibited Employment;
- the date MCTWF fails to receive a monthly Contribution when due; or
- the effective date of (1) termination of Program coverage as determined by the Trustees, or (2) an amendment to the Program by the Trustees that makes you no longer eligible.

If your Program coverage ends as a result of your engagement in Prohibited Employment or failure to make a monthly self-Contribution when due, you cannot re-elect this coverage at any time for any reason.

### **When Your Spouse's Retiree Medical Program Coverage Ends**

Your Spouse's coverage under the Program will end on the first of the following dates:

- the date your Spouse reaches age 65;
- the date your Spouse becomes eligible for Medicare coverage, except in the case of ESRD as stated above;
- the date you and your Spouse become divorced;
- the date your Spouse remarries after your death;
- the date MCTWF fails to receive a monthly self-Contribution when due;
- the date of your Spouse's death;
- the date you become eligible for coverage under an MCTWF Plan as an Active Employee; or
- the effective date of (1) termination of the Retiree Medical Program as determined by the Trustees, or (2) an amendment to the Program by the Trustees that makes your Spouse no longer eligible.

If your Spouse's Program coverage ends due to a failure to make a monthly self-Contribution when due, you cannot re-elect this coverage at any time for any reason.

Except as otherwise noted, all references above to "Medicare" include both early age (Disability) and normal age Medicare Part A coverage. All references above to attaining age 65 refer to the last day of the month preceding the month in which the 65th birthday falls.

## **Recognition of Other Fund Participation - Reciprocity**

If Contributions were made to MCTWF on your behalf during the 26 or more weeks immediately before your Retirement Date and your participation in an MCTWF Plan commenced prior to November 30, 2003, you will receive credit for prior Contributions made on your behalf under the Central States, Southeast and Southwest Areas Health and Welfare Fund. This credit is used to determine whether you meet the Contribution requirements for Retiree Medical Program coverage.

### **2.3(b) RETIREE DEATH BENEFIT PROGRAM**

**Retirees:** To be eligible for coverage under the Retiree Death Benefit Program a Retiree must -

- be enrolled in the Retiree Medical Program; and
- file a completed application for enrollment by the later of 90 Days after his MCTWF Retirement Date or 30 Days after the date of MCTWF's letter approving the application for enrollment in the Retiree Medical Program.

**Spouse of Retiree:** To be eligible for coverage under the Retiree Death Benefit Program, a Retiree's Spouse must -

- be enrolled in the Retiree Medical Program; and
- file a completed application for enrollment by the later of 90 Days after the Retiree's MCTWF Retirement Date or 30 Days after the date of MCTWF's letter approving the application for enrollment in the Retiree Medical Program.

#### **Special Circumstances:**

A Retiree who marries after enrolling in the Retiree Death Benefit Program may obtain Spouse coverage under the Retiree Death Benefit Program by filing a completed application for enrollment within 90 Days after the marriage.

If a Retiree met the requirements for eligibility, but died before enrolling in the Retiree Death Benefit Program, the surviving Spouse may obtain coverage by filing a completed application for enrollment by the later of 90 Days after the Retiree's MCTWF Retirement Date or 30 Days after the date of MCTWF's letter approving the application for enrollment in the Retiree Medical Program.

Upon the death of a Retiree, the Retiree's surviving Spouse who is Covered under the Retiree Death Benefit Program may continue coverage by continuing to make timely Contributions to MCTWF in the amounts on the schedule established by the Trustees for Spouse coverage under the Retiree Death Benefit Program.

## **Enrolling**

To enroll in the Retiree Death Benefit Program, a Retiree and/or eligible Spouse must file a completed MCTWF *Retiree Death Benefit Program Application Form* with the MCTWF office by the later of 90 Days after the Retiree's MCTWF Retirement Date or 30 Days after the date of MCTWF's letter approving the application for enrollment in the Retiree Medical Program.

Within 30 Days after receiving the *Retiree Death Benefit Program Application Form*, the MCTWF office will notify the Retiree and/or Spouse of eligibility for the Retiree Death Benefit Program. If eligibility is granted, MCTWF will provide an MCTWF *Retiree Death Benefit Program Election Form* to the Retiree and/or Spouse.

Within 30 Days following the date on the *Retiree Death Benefit Program Election Form*, the Retiree and/or Spouse must file the completed election form with the MCTWF office along with a Contribution for three months (one quarter). Coverage will commence on the first day of the following month if postmarked or hand delivered on or before the 20th of the month.

For example, If your return envelope is postmarked or hand delivered to MCTWF on or before January 20th coverage will commence on February 1st. If your return envelope is postmarked or hand delivered after January 20th coverage will commence on March 1st.

### **Contributions**

Quarterly Contributions under the Retiree Death Benefit Program will be based on the individual's (Retiree or Spouse) age at the time of the Retiree's initial participation in the Retiree Medical Program. The first Contribution for a three-month period (quarter) must be filed with MCTWF along with the completed *Retiree Death Benefit Program Election Form*. Thereafter, Contributions must be paid for each successive quarter and must be filed with MCTWF on or before the 20th day of the month preceding the quarter for which payment is due. Upon receiving a quarterly Contribution, MCTWF will send a statement to the Retiree and/or Spouse for the following quarter. Contributions will not be accepted beyond the current quarterly Contribution period due. All Contributions received must include the social security number of each eligible Participant.

Failure by MCTWF to provide a statement for quarterly Contributions does not relieve a Retiree or Spouse from the obligation to make timely Contributions. It is the responsibility of each Retiree and/or Spouse to send timely payments to MCTWF. Coverage under the Retiree Death Benefit Program will terminate if Contributions are not filed with MCTWF within the time required. Late Contributions will be accepted if payment for the quarter past due is received by the 15th of the month following the quarter due, together with a \$50 late fee. Participants who have not made payment by the last business day of the quarter 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 following the quarter due, coverage will be terminated, regardless of the reason (including non-receipt of the late notice). There will be no reinstatement of coverage under the Retiree Death Benefit Program following termination.

Contributions are non-refundable upon the termination of coverage under the Retiree Death Benefit Program. Furthermore, Contributions attributable to unexpired portions of a quarter are not refundable upon the termination of coverage under the Retiree Death Benefit Program.

## PART 3: MEDICAL BENEFITS - ACTIVE & RETIREE PLANS

Medical benefits under your MCTWF Plan may be subject to Deductible, Copayment and Coinsurance amounts. Each of these terms are defined in the glossary at the end of this Booklet. Unless you are a Retiree participating in the MCTWF Retiree Medical Program, your medical and prescription drug benefits are subject to a per person, five million dollar lifetime benefit maximum (counting all MCTWF Plans in which you may participate) and may be subject to certain Annual benefit maximums as well. Your MCTWF Plan may also provide for limits on your Annual exposure to Coinsurance charges (i.e., an Out-of-Pocket Maximum).

Generally, if your Employer bargains out of one MCTWF Plan into another, or you change Employers and consequently change MCTWF Plans, all accrued benefit Deductible and Coinsurance amounts will be transferred to the new MCTWF Plan. Please refer to your Schedule of Benefits to determine what benefits are Covered under your MCTWF Plan and how they are paid.

### SEC. 3.1: NETWORK AND OUT-OF-NETWORK PROVIDERS

MCTWF has entered into arrangements with Preferred Provider Organizations (PPOs), which are Networks of Hospitals, Doctors and other health care providers. These providers are obligated to accept agreed-upon fees as payment in full for services. Therefore, when you use the services of Hospitals or health care providers within a Network, or Network providers, you are only responsible to pay your applicable Deductible, Copayment and Coinsurance amounts that are listed in your Schedule of Benefits.

You may choose to use Hospitals or health care providers that are not in the Network, or Out-of-Network providers. Because MCTWF does not have a fee arrangement with Out-of-Network Hospitals and health care providers, they may charge whatever they want and may expect to receive total payments equal to their charge. If the charges of Out-of-Network providers are greater than the Maximum Allowable Benefit amount paid by your MCTWF Plan, you will be responsible to pay the balance of the bill.

When you use Out-of-Network providers, you must pay the Deductible, Copayment and Coinsurance amounts that are listed in your Schedule of Benefits. However, if you are away from home and experience an urgent medical condition requiring immediate attention and the MCTWF office is not open to direct you to a local Network provider, so long as services are not obtained from a Hospital emergency room, MCTWF will waive Out-of-Network Deductible and Coinsurance charges for urgent care services obtained from an Out-of-Network provider. You will be liable for any provider charges in excess of MCTWF's Maximum Allowable Benefit amount and any in-network Deductible, Copayment and Coinsurance amounts. Maximum Allowable Benefit amounts, any amounts paid and any remaining financial responsibility you may have, along with an explanation of how the claim was processed is stated on the MCTWF *Explanation of Benefits* form that you receive from your MCTWF Plan for each claim processed. You should also refer to your Schedule of Benefits to determine how Out-of-Network benefits are paid. You may switch between Network and Out-of-Network providers as often as you choose.

The Blue Cross Blue Shield (BCBS) PPO Network is the MCTWF nationwide medical Network for Hospitals and Physicians. To be eligible for in-network level benefits, you must use a BCBS PPO Network provider. You will be responsible for applicable Deductible, Copayment and Coinsurance amounts at the in-network benefit level. Covered services received from any provider outside of the BCBS PPO Network are subject to Out-of-Network payments described above. All claims for Out-of-Network services must be submitted to the local BCBS Plan for payment.

The BCBS PPO Network is designed to meet all your health care needs, including care by specialists. However, in the event a particular service or specialty is not available in the BCBS PPO Network, your BCBS PPO Network Physician may decide to refer you outside the BCBS PPO Network. The non-BCBS PPO Network provider must submit the referral form with the claim to ensure coverage at in-network benefit levels. If the referred provider does not participate in the BCBS Traditional Network or MultiPlan Network, you will be subject to balance billing for charges in excess of MCTWF's Maximum Allowable Benefit.

You also have access to the BCBS Traditional Network or MultiPlan Network, in which case provider reimbursement will be subject to Out-of-Network Deductible, Copayment and Coinsurance amounts but you will not be subject to balance billing for charges in excess of MCTWF's Maximum Allowable Benefit amount.

MCTWF is required to furnish you automatically and without charge, a list of its Network of Physicians and other health care providers. This listing is referred to as the participating provider directory. You may also visit MCTWF's website to link to the BCBS PPO Network and MultiPlan Network websites to obtain up-to-date lists of Network Hospitals and health care providers.

### **3.1(a) WORLDWIDE NETWORK PROVIDERS**

BlueCard Worldwide, gives you access to medical care when you are outside of the United States. For non-emergency inpatient medical care, you must call the BlueCard Worldwide service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177. The service center is staffed with multilingual representatives and is available 24 hours a day, seven days a week. By making arrangements through the service center your medical services will be Covered at in-network benefit levels. If you need emergency medical care, you may seek reimbursement by completing a BCBS *International Claim Form* and sending it to the BlueCard Worldwide service center. Reimbursement will be subject to Copayments and other emergency service limits (see page 31, Sec. 3.15, Emergency Services).

### **3.1(b) CERTAIN OUT-OF-NETWORK PROVIDER SERVICES COVERED AT IN-NETWORK LEVELS**

The below listed provider categories do not participate in the BCBS PPO Network, but do participate in the BCBS Traditional Network. Services obtained from BCBS Traditional Network providers in the following categories will be Covered at in-network benefit levels:

- ambulance providers;
- ambulatory surgical centers;
- certified nurse anesthetist;
- certified nurse midwives;
- certified nurse practitioners;
- Durable Medical Equipment suppliers;
- hearing aids suppliers;
- home health care providers;
- hospice providers;
- medical supply providers;
- private duty nursing providers; and
- prosthetic and orthotic suppliers.

## **SEC. 3.2: IF YOU DO NOT HAVE ACCESS TO NETWORK PROVIDERS**

### **3.2(a) MEDICAL CARE**

MCTWF is dedicated to providing you with affordable health care within your community. If you live further than 20 driving miles (as determined by MCTWF) from a Network Primary Care Physician (PCP) or 50 driving miles from a Network specialist and therefore, do not have adequate access to a Network Provider, you have the option of seeking care from a PCP or specialist of your choice.

To do so, you must apply for an exemption to use an Out-of-Network provider (see the following section).

PCPs are Doctors whose main area of care is Family Practice, Internal Medicine, General Practice, Pediatrics or Obstetrics/Gynecology.

Authorized Out-of-Network services are subject to the same Deductible, Copayment and Coinsurance amounts that apply to in-network services. Payment will be made directly to the Physician (unless the claim reflects that you have paid). However, you will be responsible for any balance billed by the provider in excess of MCTWF's Maximum Allowable Benefit amounts.

### **3.2(b) NON-ACCESS EXEMPTION APPLICATION**

Your Application must be received by MCTWF within 60 Days following the date of receipt of Out-of-Network services. The claim will be deemed as Out-of-Network and all applicable Deductible, Copayment and Coinsurance amounts will apply. The approval will continue for six months from the date that the first Out-of-Network services are rendered. Any services beyond the six month period must be authorized pursuant to the submission and approval of your new application. You may obtain an MCTWF *Non-Access Exemption Application* form, by calling MCTWF's Customer Communications Department or from MCTWF's website.

## **SEC. 3.3: USING YOUR IDENTIFICATION CARDS**

You should present your MCTWF Networks Card and your Blue Cross ID card at the time you receive medical services. Only your MCTWF Networks Card is necessary to receive services at participating pharmacies.

When you present your card for medical services, claims for the services will be sent directly to the local Blue Cross Blue Shield Plan for processing by the provider (see page 72, Sec. 13.1, Claims for Medical Benefits, for information about filing claims for medical benefits).

## **SEC. 3.4: SCHEDULE OF BENEFITS**

Your Schedule of Benefits contains information about your MCTWF Plan, including specific benefits and benefit types, Deductibles, Copayments, Coinsurances and benefit maximums, and is included as part of your SPD Booklet.

## **SEC. 3.5: MEDICAL EXPENSES - COST SHARING AND LIMITS**

### **3.5(a) ALLOWED AMOUNTS**

Allowed Amounts are the portion of the Amount Billed which has been established either by contract with the provider, or in the case of an Out-of-Network provider, as your MCTWF Plan's Maximum Allowable Benefit, which are subject to Plan Deductible, Copayment and Coinsurance amounts, as well as Out-of-Pocket, and benefit Maximums.

### **3.5(b) DEDUCTIBLE**

The Deductible amount is the amount of Covered medical expenses you must pay Annually before your MCTWF Plan begins paying on a calendar year basis (January 1st through December 31st). The Deductible may apply to the individual, or the family, or both.

### **3.5(c) COINSURANCE**

The Coinsurance amount is the percentage of the Allowed Amounts you must pay regardless of any individual or family Deductible amount for which you are responsible.

### **3.5(d) COPAYMENT**

The Copayment amount is the flat dollar amount you are responsible for paying when you receive medical services. How much you pay depends on the service provided.

### **3.5(e) OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum shown in your Schedule of Benefits limits the amount of money that you will have to spend for Coinsurance charges during each calendar year.

### **3.5(f) LIFETIME BENEFITS MAXIMUM**

All MCTWF Plans, with the exception of the Retiree Medical Program, have a per person, lifetime medical and prescription drug benefit maximum of five million dollars, which is the maximum amount MCTWF will pay in benefits during that individual's lifetime, counting all MCTWF Plans in which an individual participates.

### **3.5(g) MAXIMUM ALLOWABLE BENEFIT**

Maximum Allowable Benefit means your MCTWF Plan's allowable portion of the Amount Billed by a provider that does not participate in the BCBS, MultiPlan, ValueOptions or Delta Dental of Michigan networks, subject to Deductible, Copayment and Coinsurance amounts.

## **SEC. 3.6: PRIOR AUTHORIZATION**

Prior Authorization is required for certain procedures, services and products to allow for payment of benefits under your MCTWF Plan. If services are performed, but not prior authorized, you may be responsible for full payment of charges. Those services are -

- blepharoplasty and ptosis repair; upper lid;
- breast reduction;
- breast reconstruction;
- colonoscopy screening (except those that meet the wellness benefit criteria);
- Durable Medical Equipment-purchase;
- growth hormone stimulation;
- home health care;
- hospice;
- human organ transplants;
- mental health and substance abuse treatment;
- PET scans;
- CT scans;
- Skilled Nursing Facility care; and
- nuclear cardiology.

Most prior authorizations require written submission from the provider to MCTWF. If your provider has questions or concerns he should contact the appropriate party by referring to Important Phone Numbers listed at the front of this Booklet.

## **SEC. 3.7: HOSPITAL**

### **3.7(a) ROOM AND BOARD**

Your MCTWF Plan pays for your Hospital semi-private room and board for treatment of a general medical condition as long as you are eligible for benefits at the time of commencement of the confinement. If you are re-admitted into the Hospital within 30 Days from the prior discharge for the same condition, the Copayment for the re-admission is waived. Expenses for a private room will be Covered if Medically Necessary. Certain specialized care has limited Days of coverage, as noted in your Schedule of Benefits, and other restrictions, as noted in the descriptions of benefits that follow.

### **3.7(b) OTHER HOSPITAL SERVICES**

Your MCTWF Plan pays for other Hospital services provided by the Hospital, Hospital staff member or prescribed by your Doctor while you are confined as an inpatient and include but are not limited to -

- treatment in special care units such as burn, cardiac or intensive care;
- general nursing services;
- operating, delivery and treatment rooms and equipment;
- anesthesia;
- laboratory examinations;
- physical therapy;
- oxygen and other gas therapy;

- drugs and medicines;
- supplies for dressings and plaster casts;
- use of radium, when owned and operated by the Hospital;
- prescription drug infusion therapy (for a course of treatment) and intravenous therapy (for one dose of treatment); and
- dialysis.

Certain Out-of-Network Hospital services are subject to in-network Deductible, Copayment and Coinsurance amounts despite the provider's non participation in the BCBS PPO Network. These services are characterized by the fact that you have little or no control over which provider performs the service, as follows:

- ambulance;
- anesthesiology;
- radiation therapy;
- radiology;
- laboratory;
- pathology;
- emergency room Physician; and
- nuclear medicine.

If the provider does not participate in the BCBS Traditional Network or MultiPlan Network, you may be subject to balance billing for charges in excess of MCTWF's Maximum Allowable Benefit schedule, in addition to any in-network level Deductible, Copayment and Coinsurance amounts.

### **SEC. 3.8: SURGICAL**

Your MCTWF Plan pays for surgical services.

### **SEC. 3.9: SECOND AND THIRD MEDICAL OPINIONS**

Your MCTWF Plan pays up to the Maximum Allowable Benefit charge for a second and third opinion (including diagnostic lab tests and diagnostic imaging) regarding a previously recommended medical treatment or surgical procedure, even if you choose not to follow the Doctor's advice. In order to receive these benefits, the Doctor must include the appropriate code to indicate that the charges are for a second or third opinion.

### **SEC. 3.10: DIAGNOSTIC IMAGING**

Your MCTWF Plan pays for diagnostic imaging services.

### **SEC. 3.11: LABORATORY TESTS**

Your MCTWF Plan pays for laboratory tests.

### **SEC. 3.12: PHYSICIAN VISITS**

Your MCTWF Plan pays for Physician's office visits and in-Hospital Physician visits.

### **SEC. 3.13: SKILLED NURSING FACILITY**

Your MCTWF Plan pays for room and board and other medical services if you are transferred to a Skilled Nursing Facility care immediately following a Hospital stay. Your provider must obtain prior authorization for Skilled Nursing Facility care (see page 29, Sec. 3.6, Prior Authorization, for instructions).

### **SEC. 3.14: EMERGENCY SERVICES**

Your MCTWF Plan pays for emergency room treatment for emergency injuries and emergency illnesses. Your MCTWF Plan will hold you harmless from balance billing when no Network choice is reasonably available, until the acute emergency phase is resolved. In the event that you are admitted directly into the Hospital, the emergency room Copayment is waived and only the Hospital admission Copayment applies.

Emergency illnesses mean the sudden, unexpected, worsening or onset of a condition that threatens your life or significant worsening of the underlying condition if medical attention is not received. Some examples of such emergency illnesses include heart attacks, strokes, loss of consciousness, convulsion, increasing or sudden shortness of breath and unexplained chest pain.

Emergency injuries include, but are not limited to fractures, strains, sprains or cuts requiring immediate professional treatment, eye injuries, head injuries, swallowing of poisons, medication overdose, allergic reactions caused by insect stings or bites, animal bites, burns, smoke inhalation, heat prostration and frostbite.

In general, routine care for minor or chronic medical problems such as chronic or recurring headaches, colds, slight fevers, minor or chronic back pain treated in an emergency room are not Covered by your MCTWF Plan.

### **SEC. 3.15: AMBULANCE SERVICES**

Your MCTWF Plan pays for ground, air or water ambulance services for basic and advanced life support and transportation to a medical facility for treatment of a medical emergency, or from one Hospital facility to another for reasons of medical necessity. Transfer from one Hospital facility to another and back, to receive treatment recommended by a Doctor but not available at the facility of origin, is also Covered. Due to the emergent nature of these services, such services provided by Out-of-Network providers are treated as in-network with respect to Deductible, Copayment and Coinsurance amounts. If the provider does not participate in the BCBS Traditional Network or MultiPlan Network, you will be liable for any provider charges in excess of MCTWF's Maximum Allowable Benefit in addition to any required in-network level Deductible, Copayment and Coinsurance amounts.

These services are considered eligible when transport is Medically Necessary because transport by any other means would endanger your health or the injury requires immediate first aid to stabilize you before transport to a Hospital.

Air ambulance services are payable only when all of the following criteria are met:

- the use of an air ambulance is Medically Necessary and ordered by a Physician;
- no other means of transport is available, or your condition requires transportation by air rather than ground or water ambulance;
- you are 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.

## **SEC. 3.16: MATERNITY**

Your MCTWF Plan pays for pre-natal care, post-natal care and obstetrical services.

Your MCTWF Plan pays for Hospital room and board charges and other Hospital services for pregnancy, childbirth (including well baby newborn Hospital services rendered to the newborn), miscarriage or therapeutic abortion for you.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

### **3.16(a) MIDWIFE SERVICES**

Your MCTWF Plan pays for certain services for pregnancy, childbirth and miscarriage provided by a Certified Nurse Midwife (CNM). All fifty states certify CNMs, with most having a master's degree level in training. Your MCTWF Plan does not pay for services provided by a direct-entry midwife. Not all states license these practitioners. MCTWF will not allow benefits for both a CNM and a Physician, unless there are complications that require the intervention of a Physician. Subject to MCTWF Plan limits, CNM services are Covered for the following procedures:

- normal vaginal delivery when provided in an inpatient Hospital setting or a birthing center which is Hospital affiliated, state licensed and accredited as defined and approved by BCBS;
- pre-natal care; and
- post-natal care, including a PAP smear.

## **SEC. 3.17: HOME HEALTH CARE**

Receiving care in your home is often more desirable than remaining in the Hospital. Your MCTWF Plan pays for home health care services for you if -

- you are homebound or normally unable to leave home unassisted;

- the treating Physician recommends home health care and it is prescribed under a home health care treatment plan; and
- you require intermittent skilled nursing care, physical therapy, speech-language pathology services or continued occupational therapy.

Your MCTWF Plan pays for home health care services, provided that you have received prior authorization from MCTWF (see page 29, Sec. 3.6, Prior Authorization, for instructions).

### **3.17(a) NURSING CARE**

Your MCTWF Plan pays for graduate registered nurse (RN) services and licensed practical nurse (LPN) services, including private-duty nursing, as long as the service is not provided by a family member, and the services have MCTWF prior authorization as part of the home health care benefit.

Services of home health care nurses are limited as follows:

- Daily home health care visits are limited to the number of visits approved by MCTWF as necessary for a particular course of treatment; and
- Up to 24 hours of care per day for 5 Days lifetime maximum, up to 16 hours of care per day for 45 Days lifetime maximum and up to 8 hours of care per day for 900 Days lifetime maximum.

### **SEC. 3.18: HOSPICE**

Hospice care provides for routine home care, services in an extended care facility, and general inpatient care in an approved hospice program, and is designed specifically to treat the terminally ill concentrating on pain management and professional counseling for both patients and their families.

Your MCTWF Plan pays for hospice care services, provided that you have received prior authorization from MCTWF (see page 29, Sec. 3.6, Prior Authorization, for instructions), for traditional hospice services for up to 12 months, providing a transitional period (“phase one”) as part of the 12 month benefit. Phase one hospice care consists of evaluation, support services, consultation and education for you and your family, is limited to one visit per Day and continues until you and your Physician agree to forgo curative treatment for the terminal illness and proceed with the traditional hospice services.

### **SEC. 3.19: RESPITE CARE**

Your MCTWF Plan pays for respite care services up to a maximum of 24 hours per day for no more than seven Days, when approved in advance by MCTWF as part of the hospice benefit prior authorization.

### **SEC. 3.20: CHIROPRACTIC SERVICES**

Your MCTWF Plan pays for the chiropractic services, and diagnostic imaging and for those diagnoses deemed by BCBSM as treatable with chiropractic services, 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).

Non-surgical spinal decompression therapy services rendered will be subject to Out-of-Network Deductible, Copayment and Coinsurance amounts.

### **SEC. 3.21: OPHTHALMOLOGY AND OPTOMETRY SERVICES**

Your MCTWF Plan pays for eligible expenses for services rendered by and ophthalmologist or optometrist within their licensed scope of treatment and which meets MCTWF's medical necessity criteria.

### **SEC. 3.22: HEARING**

Your MCTWF Plan pays a hearing benefit once every two Years. The benefit is a scheduled amount which includes -

- hearing aids (excluding Participants under the Retiree Medical Program Plan who have not purchased the Retiree Supplemental Benefits Rider);
- an audiometric examination, which evaluates your hearing and measures hearing loss;
- a hearing aid assessment to determine which type of device would best address your needs; and
- a conformity test, which is a follow up visit to ensure that the purchased hearing aid is performing as specified.

#### **3.22(a) COVERED HEARING AID ITEMS**

Hearing aids that are Covered by your MCTWF Plan are -

- behind the ear;
- custom in the ear; or
- body aid type hearing aids.

#### **3.22(b) HEARING AID ITEMS NOT COVERED**

Your MCTWF Plan does not pay for the following items related to hearing aids:

- batteries;
- extended warranties;
- fittings;
- hearing aid repairs; or
- early replacement due to loss or damage.

Hearing aids vary in cost depending upon quality and technical capabilities. You should discuss with your provider, prior to receiving services, any out-of-pocket expense to which you may be exposed.

### **SEC. 3.23: DURABLE MEDICAL EQUIPMENT (DME)**

Durable Medical Equipment (DME) is equipment that can withstand repeated use and is primarily used to serve a medical condition. Your MCTWF Plan pays for DME equipment rental or purchase (rental or purchase is determined by the length of time and/or type of equipment prescribed). All DME rentals and purchases must be prescribed and certified as Medically Necessary by a licensed Physician, and obtained from a provider who Blue Cross Blue Shield (BCBS) has certified as a DME supplier. Equipment includes wheelchairs, Hospital beds, oxygen tents and other items required for the care of you in the home. All purchases and repair of DME basic equipment, special features and accessories must be prior authorized through MCTWF (see page 29, Sec. 3.6, Prior Authorization, for instructions), with the exception of DME Covered batteries, canes, crutches, walkers, nebulizers, insulin pumps Covered under the BCBSM Diabetes Management Program and glucometers.

A full list of Covered DME equipment can be found on the Schedule of Benefits page of the MCTWF's website.

The following types of equipment are not considered DME and are examples of non-Covered items:

- comfort or convenience items;
- exercise and hygienic equipment;
- Physician's equipment;
- self help devices;
- spare equipment; and
- disposable equipment.

### **SEC. 3.24: MEDICAL SUPPLIES**

Your MCTWF Plan pays for medical supplies. Medical supplies are supply items that are generally disposable, non-durable and Medically Necessary. All medical supplies must be prescribed and certified as Medically Necessary by a licensed Physician, and obtained from a provider whom Blue Cross Blue Shield (BCBS) has certified as a medical supplies provider. Medical supplies include lancets, test strips, masks, hoses, dressings, tubing, etc., of which some have quantity limits, including one intra-uterine device in a three year period with the insertion and removal Covered under the surgical portion of your MCTWF Plan. Comfort and convenience items are not considered medical supplies and are not Covered. A full list of Covered medical supplies can be found on the Schedule of Benefits page of MCTWF's website.

To determine whether a specific DME or medical supply item is a Covered item, or to determine whether a provider is a BCBS certified supplier, you may contact the MCTWF Customer Communications Department or access it from MCTWF's website. While the list does not contain quantity limits, all BCBS certified suppliers are aware of these restrictions.

### **SEC. 3.25: WELLNESS**

Your MCTWF 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, as well as balance billing.

**3.25(a) TYPES OF COVERED SERVICES**

For women, your MCTWF wellness benefit pays for the following:

- mammography screening - one baseline screening between the ages of 35 and 40 years and one screening annually age 40 years and older;
- cervical cancer screening (Pap smear) - once annually;
- physical examination - once annually;
- gynecologic pelvic examination - once annually;
- electrocardiogram (EKG) - once annually;
- stool occult blood tests - once annually age 50 years and older;
- colonoscopy or flexible sigmoidoscopy screening - once every five Years age 50 years and older or African American at age 45 years. On a one time only basis, if the colonoscopy follows a sigmoidoscopy, the five year limitation does not apply;
- bone density testing - once for menopausal women, with follow-up testing once every two Years;
- Human Papillomavirus (HPV) immunization - one series between the ages of 18 and 26, if was not received between ages 9 and 18;
- Human Papillomavirus (HPV) Annual DNA testing for women age 30 or older; and
- influenza vaccination - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

For men, your MCTWF wellness benefit pays for the following:

- Prostate Specific Antigen (PSA) tests - once annually age 40 years and older;
- stool occult blood tests - once annually age 50 years and older;
- physical examination - once annually;
- colonoscopy or flexible sigmoidoscopy screening - once every five Years age 50 years and older or African American at age 45 years;
- electrocardiogram (EKG) - once annually; and
- influenza vaccination - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

For children, your MCTWF wellness benefit pays for the following:

- well baby/child physical examinations - one examination in conjunction with each of the age recommended immunizations;
- physical examination - no more than once annually including examinations in conjunction with immunizations;
- Electrocardiogram (EKG) - once annually ages 12-18 years and older as part of a child physical examination; and
- immunizations - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

## SEC. 3.26: OTHER MEDICAL BENEFITS

### 3.26(a) BREAST RECONSTRUCTION

If you have a mastectomy, your MCTWF Plan pays for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas; and
- a maximum of two mastectomy bras per calendar year.

### 3.26(b) BARIATRIC SURGERY

Your MCTWF Plan pays for bariatric surgery for those between the ages of 18 and 60 with a diagnosis of morbid obesity who -

- have a body mass index of 40 or greater;
- have obtained a medical examination with an evaluation of any co-morbidities;
- have obtained a surgical evaluation to determine operability and surgical risk; and
- have obtained a psychological evaluation that documents your understanding of the procedure and the lifelong dietary and lifestyle modifications required.

Reconstructive surgical procedures of any kind, for any reason, occasioned directly or indirectly by the weight loss following bariatric surgery, are excluded from coverage under your MCTWF Plan.

### 3.26(c) CARDIAC REHABILITATION

Your MCTWF Plan pays for cardiac rehabilitation for a maximum of 36 treatments (three cardiac sessions per week for up to 12 weeks) and may be provided by the outpatient department of a Hospital or in a Physician's office. Coverage is subject to the following criteria:

- may be provided by the outpatient portion of a Hospital or under the supervised direction of a Physician;
- the facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as Medically Necessary, e.g., oxygen, CPR equipment or defibrillator;
- the program is conducted in an area set aside for the exclusive use of the program while it is in session;
- phase two cardiac rehab services (where rehab from losses that occurred prior to or during hospitalization are corrected) are for one of the following cardiac conditions:
  - acute myocardial infarction;
  - coronary artery bypass;
  - chronic stable angina pectoris;
  - percutaneous transluminal coronary angioplasty;
  - heart valve surgery;
  - heart transplant;
  - class III or IV congestive heart failure unresponsive to medical therapy;

- you must have a clear medical need for the services prescribed by the attending Physician; or
- the program must begin within 90 Days of a cardiac event and be completed within six months.

### **3.26(d) CHEMOTHERAPY AND RADIATION THERAPY**

Your MCTWF Plan pays for chemotherapy and services and supplies for at home administration and chemical reagents used in chemotherapy.

### **3.26(e) COLONOSCOPY SCREENING**

Your MCTWF Plan pays for colonoscopy screenings that do not meet the wellness benefit criteria and that are not billed with a medical diagnosis code if any of the following criteria are satisfied, subject to prior authorization (see page 29, Sec. 3.6, Prior Authorization, for instructions):

- an individual whose first degree relative was diagnosed with colorectal cancer at age 60 and over, or two second degree relatives diagnosed at any time, is Covered for a screening at age 40 or at 10 Years prior to the age at which the relative was diagnosed (whichever is earlier), with follow up once every five Years;
- an individual whose first degree relative was diagnosed with colorectal cancer or tubular adenoma at age 60 years or less, or two second degree relatives diagnosed at any time, is Covered for a screening at age 40 or at 10 Years prior to the age at which the relative was diagnosed (whichever is earlier), with follow up once every three Years;
- an individual with inflammatory bowel diseases, chronic ulcerative colitis, or Crohn's disease, is Covered for a screening ten Years after the onset of the disease, with follow up once per year;
- an individual with inflammatory bowel diseases, chronic ulcerative colitis, or Crohn's disease with sclerosing cholangitis, is Covered for a screening at the time of diagnosis, with follow up once per year; or
- an individual with diagnosed colorectal cancer before age 50, multiple polyps (pre-cancer) before age 40, or with a family history of colorectal or other cancers, is Covered for a screening after a genetic evaluation of your cancer tissue, at which time age will be determined and follow up is determined by the genetic diagnosis made.

### **3.26(f) DENTIST AND DENTAL SURGEON SERVICES**

Your MCTWF Plan pays for services secondary to dental coverage for repair of the jaw and natural teeth as the direct result of an Accidental Injury or caused by congenital or genetic abnormalities. In either case allowed charges first will be applied against the available dental limits before being applied against your medical limits.

### **3.26(g) DIALYSIS**

Your MCTWF Plan pays for dialysis services when required to provide an artificial replacement for lost kidney function due to renal failure.

### **3.26(h) DIETARY COUNSELING**

Your MCTWF Plan pays for unlimited dietary counseling by a certified dietician for certain diagnostic categories. To obtain a list of Covered categories contact the MCTWF Customer Communications Department.

### **3.26(i) EXPERIMENTAL, INVESTIGATIVE OR OTHERWISE NOT REASONABLE OR CUSTOMARY TREATMENT**

Your MCTWF Plan pays for Medically Necessary services to correct complications arising out of Experimental, Investigative or otherwise not reasonable or customary treatment.

### **3.26(j) HYPERALIMENTATION (TPN)**

Your MCTWF Plan pays for hyperalimentation and services and supplies necessary for the administration of hyperalimentation as part of a home health care treatment program.

### **3.26(k) IMMUNIZATIONS**

Your MCTWF Plan pays for adult immunizations as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

### **3.26(l) INFUSION THERAPY**

Your MCTWF Plan pays for infusion therapy services for a course of treatment.

### **3.26(m) INJECTIONS**

Your MCTWF Plan pays for injections (e.g., allergy, antibiotic, contraceptive), when administered to treat a medical condition.

### **3.26(n) CONTRACEPTIVE MANAGEMENT**

Your MCTWF Plan pays for contraceptive management services when performed by a licensed Physician. Services include coverage for office visits for counseling and advice, and contraceptive drugs and devices supplied and administered in the Physician's office.

### **3.26(o) INTRA-ARTICULAR INJECTIONS**

Your MCTWF Plan pays for intra-articular injections of the knee with hyaluronic acid; Synvisc (hylan G-F20) and Hyalgan (sodium haluronate) for the following conditions/diagnoses:

- osteoarthritis, localized, primary, lower leg;
- osteoarthritis, localized, secondary, lower leg;
- osteoarthritis, localized, not specified whether primary or secondary, lower leg;
- osteoarthritis, unspecified whether generalized or localized, lower leg; and
- osteoarthritis, temporomandibular joint (TMJ).

Covered individuals with osteoarthritis of the knee or TMJ who have insufficient pain relief from conservative non-pharmacological therapy (e.g., physical therapy) and simple analgesics, and have failed conservative therapy with non-steroid anti-inflammatory drugs (NSAID), or who have contraindications to NSAID therapy, are eligible for a single course of three to five weekly injections.

### **3.26(p) ORTHOTIC DEVICES**

Orthotic devices (e.g., braces, collars, supports) support or correct the function of a limb or the torso. Your MCTWF Plan pays for orthotic devices, except as otherwise excluded below, when prescribed by your Physician and obtained from a provider who Blue Cross Blue Shield (BCBS) has certified as an orthotic device supplier.

In addition to the exclusions listed in the General Exclusions and Limitations (see page 1) and Medical Expenses Not Covered (see page 45, Sec. 3.30) sections of this Booklet, the following orthotic devices may be excluded as well:

- arch supports or supportive devices for the feet;
- orthotic devices used for participating in strenuous physical activity beyond normal activities or daily living;
- orthopedic or corrective shoes (except when either one of both are an integral part of a leg brace); or
- non-rigid applications such as elastic stockings, corsets or garter belts.

### **3.26(q) PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY**

Your MCTWF Plan pays for physical, occupational and speech therapy when you require therapy to restore and maintain normal function.

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Note: Since for congenital type diagnoses, therapy is required to develop and maintain function rather than to restore and maintain function, it is not Covered under your MCTWF Plan.

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### **3.26(r) PROSTHETIC DEVICES**

Your MCTWF Plan pays for prosthetic devices when prescribed by your Physician and obtained from a provider who Blue Cross Blue Shield (BCBS) has certified as a prosthetic device supplier.

### **3.26(s) SCLEROTHERAPY**

Your MCTWF Plan pays for sclerotherapy services, limited to one injection per Day, up to a maximum of 10 injections per calendar year.

### **3.26(t) SLEEP STUDIES**

Your MCTWF Plan pays for sleep studies for the following diagnoses:

- transient difficulty in initiating or maintaining sleep;
- somnambulism or night terrors;
- other dysfunctions of sleep stages or arousal from sleep;
- cataplexy and narcolepsy; and
- sleep disturbances.

### **3.26(u) SPECIAL FORMULAS AND MEDICAL FOODS**

Your MCTWF Plan pays for special formulas and medical foods prescribed for infants and young children born with certain inherited metabolic diseases per the following:

Special formulas - Physician prescribed medical formulas are Covered, without a dollar maximum, for children up to 24 months of age, if the formula represents at least half of the child's caloric intake.

Medical foods - Physician prescribed medical foods and solid, modified food supplements are Covered up to a yearly maximum of \$2,500 for children through age 18.

You can purchase special formulas and medical foods from any supplier which can include, for example, any health food store or supplier found on the internet.

Reimbursement of billed charges, subject to your MCTWF Plan limits, will be made directly to you upon MCTWF's receipt of the prescription (which will be kept on file for one year), a medical claim form and a purchase receipt.

### **3.26(v) TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION**

Your MCTWF Plan pays for services related to the diagnosis and medical treatment of temporomandibular joint dysfunction.

## **SEC. 3.27: EXTENDED DISABILITY**

If you are disabled while you are Covered under your MCTWF Plan, once your coverage has ended, benefits for services rendered in connection with the Disability may be extended for up to the earlier of 24 months or your eligibility for Medicare benefits. The first 90 Days of which provides coverage at payment levels based on whether you have chosen a Network or Out-of-Network provider, subject to any Deductible, Copayment or Coinsurance amount required under your MCTWF Plan. For the last 21 months, coverage is limited to Out-of-Network levels of coverage regardless of whether you use a Network or Out-of-Network provider.

To qualify for extended disability, all of the following requirements must be met:

- you were totally disabled when coverage ended and remain continuously disabled until the date the medical expense is incurred;
- the treatment or services result from the same injury or Illness that existed on the date your coverage ended and that caused your total Disability;
- you provide documentation from your Physician validating the Disability which must be filed within fifteen months from the date your Active coverage ceases;

- the expenses are Covered by your MCTWF Plan; and
- the treatment or services are received within two Years after your coverage ended.

### SEC. 3.28: HUMAN ORGAN AND TISSUE TRANSPLANT

Your MCTWF Plan pays benefits up to a maximum amount as reflected in the benefit maximum chart below. All organ transplants, excluding kidney transplants, require prior authorization. Should you require a transplant, your Doctor or Hospital should contact Blue Cross Blue Shield. You may also contact the MCTWF Customer Communications Department for assistance. Coverage is available only if the transplant is not considered Experimental in nature and all other eligibility provisions are satisfied.

The benefit is limited to the following maximums:

Transplant Procedure/ Organ	Surgical Benefits	Annual Follow-Up Benefits	Lifetime Follow-Up Benefits
Bone Marrow Autologous	\$150,000	\$25,000	\$100,000
Bone Marrow Allogeneic	\$200,000	\$25,000	\$100,000
Bone Marrow Allogeneic Unrelated	\$250,000	\$25,000	\$100,000
Heart	\$175,000	\$25,000	\$100,000
Heart/Lung	\$200,000	\$25,000	\$100,000
Kidney (no prior authorization required)	\$100,000	\$25,000	\$100,000
Intestine	\$250,000	\$25,000	\$100,000
Liver	\$150,000	\$25,000	\$100,000
Liver (partial)	\$175,000	\$25,000	\$100,000
Liver/Intestine	\$325,000	\$25,000	\$100,000
Liver/Kidney	\$175,000	\$25,000	\$100,000
Liver/Pancreas/Intestine	\$350,000	\$25,000	\$100,000
Lung	\$200,000	\$25,000	\$100,000
Lung (lobar)	\$200,000	\$25,000	\$100,000
Pancreas	\$100,000	\$25,000	\$100,000
Pancreas/Intestine	\$325,000	\$25,000	\$100,000
Pancreas/Kidney	\$125,000	\$25,000	\$100,000

#### 3.28(a) COVERED EXPENSES

MCTWF provides coverage for five phases of transplant services as follows:

Phase I – Pre-Transplant Evaluation. This phase covers health services that are required to evaluate you for acceptance into a transplant program, subject to any limitations that are contained in your MCTWF Plan. Health services under Phase I covers inpatient health care, outpatient health care and services of health care professionals. Phase I includes health services related to testing, HLA typing and donor identification for living-related and unrelated kidney and allogeneic bone marrow transplants.

It also includes the harvesting and storage of bone marrow tissue for autologous bone marrow transplants. Phase I ends and Phase II begins at the time it is determined that you are an appropriate candidate for a transplant.

Phase II – Pre-Transplant Care. This phase covers health services provided following your acceptance into a transplant program and before the approved transplant takes place, subject to any limitations contained in your MCTWF Plan. Health services under Phase II are -

- routine inpatient care;
- home care health services;
- intensive care;
- services of health care professionals;
- outpatient services;
- outpatient protocol-specific drugs and/or biological agents, including prophylactic antiviral, antibacterial, antifungal, growth stimulating and chemotherapy agents that are required as part of the protocol, ordered by or under the direction of an assigned transplant team provider and are required immediately before the approved transplant procedure; and
- all ancillary services associated with the care provided.

Phase III – Transplant Procedure. This phase covers those health services required during the approved transplant through your discharge from the Hospital, subject to any limitations contained in your MCTWF Plan. Health services under Phase III are -

- organ or tissue procurement;
- transportation and preparation of organ or tissue;
- inpatient health care services;
- surgical procedures;
- ancillary health care services;
- services of health care professionals, including, but not limited to Physician services, nursing services, anesthesiology services; and
- testing and donor identification for approved transplants other than living-related and unrelated kidney and allogeneic bone marrow transplants.

Phase IV – Post-Procedure Global Period. This phase covers those health services following your Hospital discharge for up to 12 months following the date of the approved transplant, subject to any limitations contained in your MCTWF Plan. Phase IV health services include, but are not limited to -

- additional inpatient or outpatient services;
- inpatient rehabilitation services;
- total parenteral nutrition;
- home health care services;
- services of licensed health care professionals, such as Physician services, nursing services and anesthesiology services; and
- take-home supply of outpatient pharmaceuticals, including immunosuppressives received from the Hospital.

Additional approved transplants that you may require during Phases III or IV as a replacement of a previous transplant are considered a separate transplant allowing for the maximum surgical benefit.

Phase V – Post Phase IV Health Services. This phase covers any additional inpatient or outpatient health services of licensed health care professionals from the conclusion of Phase IV. Benefits are subject to any limitations contained in your MCTWF Plan.

Benefit Limitations. The following table shows the benefits and limitations that apply to each phase of the human organ transplant benefit:

Transplant Service Phase	Benefit/Limitations
I	Medical Benefit/Applicable Plan Limitations and Exclusions
II	Medical Benefit/Applicable Plan Limitations and Exclusions
III	Human Organ Transplant Benefit/Surgical Limitation
IV	Human Organ Transplant Benefit/Surgical Limitation
V	Human Organ Transplant Benefit/Annual Follow-up Limitation

**Continuation of Transplant Benefits at Retirement.** If you retire during any of the transplant service phases, including the start of Phase I, your transplant benefits will continue if you are eligible for Retiree Medical Program benefits. Transplant benefits will continue until the maximum transplant benefits are exhausted.

### **3.28(b) ORGAN TRANSPLANT DONOR COVERED EXPENSES**

Your MCTWF Plan pays for expenses for medical treatment that the donor receives in connection with the donation of an organ. Your MCTWF Plan pays for these charges only when the donor does not have a group or individual health insurance policy that would cover these charges and only when the transplant recipient is Covered under an MCTWF medical Plan.

The organ transplant benefit maximums apply to medical expenses of the donor. If the donor and the recipient of the organ are both Covered under an MCTWF Plan, each individual will receive separate organ transplant benefit maximums.

## **SEC. 3.29: MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT**

ValueOptions is the Network provider of services for all Mental Health and Substance Abuse Treatment, both inpatient and outpatient. All inpatient and outpatient services require the patient to receive prior authorization through ValueOptions. Benefits are determined by the Network or Out-of-Network provider you have selected.

Your MCTWF Plan pays for substance abuse professional (SAP) services if you are discharged by your Employer as the result of testing positive for alcohol or illegal drug use and are required to meet with a SAP professional and successfully complete a course of education and/or treatment.

### SEC. 3.30: MEDICAL EXPENSES NOT COVERED

In addition to the items shown in the General Exclusions and Limitations section of your SPD Booklet, the following types of medical services and care are not Covered by your MCTWF Plan:

- massage therapy, or acupuncture;
- any vision correction services;
- dental treatment or operation;
- personal comfort items while hospitalized, including but not limited to telephones and televisions;
- the portion of a private room charge in excess of the rate for a semi-private room unless Medically Necessary and ordered by your Doctor;
- surgical procedures, treatment or hospitalization primarily for cosmetic purposes;
- services to correct complications arising out of cosmetic procedures even when Medically Necessary;
- any treatment or service not provided or ordered by a Physician;
- expenses that exceed specified benefit levels listed in your Schedule of Benefits;
- any medical, surgical or psychotherapy expenses related to sex change operations;
- charges for care, treatment, services and supplies that are considered Experimental or Investigative in nature and/or not considered reasonable and customary by any government agency or subdivision (including as provided in the CMS Medicare Coverage Issues Manual), except Medically Necessary services to correct complications arising out of such services;
- expenses that exceed the Maximum Allowable Benefit amount, Contracted Charges or MCTWF Plan limits;
- any treatment, except dietary counseling, maternity and wellness care that is not the result of an injury or illness;
- treatment for obesity when billed as an isolated diagnosis;
- medical or surgical therapies and procedures for sterility/infertility administered strictly for the purpose of conception;
- treatment for sexual impotency when the cause is mental or emotional;
- treatment of developmental disorders without a medical diagnosis as the cause of retarded mental and/or physical development;
- bundled services provided through structured pain control/rehabilitation programs;
- benefits for Dependents in a Health Maintenance Organization (HMO) that were denied because the HMO guidelines were not followed;
- expenses for transportation or lodging, other than Medically Necessary use of an ambulance;
- expenses for Custodial Care, whether on an inpatient, outpatient or home care basis;
- expenses for drugs or medical supplies that are available over-the-counter;
- expenses for prescription drugs (excluding injectables administered in the Physician's office). However, these may be Covered under your prescription drug benefit;
- weight loss programs, except dietary counseling;
- charges for any service that requires prior authorization that was not prior authorized;
- charges for care, treatment, services and supplies that are not uniformly and professionally endorsed as standard medical care by the general medical community in the state where the treatment is rendered;
- developmental speech, occupational and physical therapy;

- charges for completion of claim forms or missed appointments;
- Deductible, Copayment and Coinsurance amounts applied for treatment, procedures, or services that were previously processed by MCTWF;
- expenses sustained while participating in an illegal act which is in violation of a State or Federal Statute;
- charges for services after coverage has been terminated, except if you are Covered under the extended Disability benefit;
- services rendered by a social worker or counselor who is not licensed in the state where services are performed;
- marriage or family counseling;
- expenses related to a transplant of an animal organ or a mechanical device to replace a human organ;
- charges you are not legally required to pay;
- charges for dyschromia (tattoo removal);
- charges for stand-by surgeons;
- charges for non-Physician surgical assistants;
- charges for educational programs or materials;
- separate charges for sales tax, surcharges and/or shipping charges;
- immunizations required for foreign travel;
- hair prosthesis, hair transplants or implants and wigs;
- expenses for employment ordered medical services;
- expenses for military service related conditions or injuries; or
- preventable Hospital acquired conditions and serious adverse events.

## PART 4: WEEKLY ACCIDENT AND SICKNESS BENEFITS

The MCTWF Plan pays the Participant weekly benefits if he is disabled while Covered by the MCTWF Plan as an Active Participant. Benefits are payable only if the Participant is incurring a loss of income as a result of his Disability. Disability means the Participant's inability to perform the regular duties of his employment because of a non-occupational or non-auto-related Accident or Sickness or due to pregnancy. The Participant may not engage in any gainful occupation during any period of Disability. Disability benefits are not payable if they occur during a period of time the Participant would not otherwise be working if the Disability had not occurred; for example, if a Disability occurs while he is laid off.

If the Disability occurs before eligibility is established, medical claims incurred will not be paid. Once eligibility is established, benefits for all eligible medical claims incurred thereafter will be provided, but weekly accident and sickness benefits in connection with the pre-eligibility Disability will not be provided.

### SEC. 4.1: HOW YOUR PLAN PAYS BENEFITS

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; or
- the eighth day following Medical Attention after the last day worked in the event of a Sickness.

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 MCTWF *Participant Report of Disability* form completed by the Physician, the Participant and his Employer.

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

Two or more periods of Disability are considered one period of Disability unless -

- the Participant returns to regular employment for at least 14 Days between disabilities; or
- the disabilities are due to unrelated causes and begin after his return to regular employment for at least one day.

### SEC. 4.2: CONTINUATION OF BENEFIT ELIGIBILITY

While the Participant is collecting weekly accident and sickness benefits, you will remain eligible for all other MCTWF Plan benefits you would otherwise be entitled to receive. Continuation of weekly accident and sickness benefits will be provided if the Participant's employment ends while he is collecting weekly accident and sickness benefits and the termination results from a layoff or from a discharge that is formally being grieved by his Local Union, until the earlier of the date of an adjudication in support of the discharge by the appropriate grievance panel and the expiration of the maximum period of weekly accident and sickness benefits.

### SEC. 4.3: HOW BENEFITS ARE TAXED

The Participant's weekly accident and sickness benefits are subject to withholding for federal FICA (Social Security) tax purposes.

## PART 5: TOTAL AND PERMANENT DISABILITY BENEFITS

The MCTWF Plan pays for Total and Permanent Disability (TPD) benefits if the Participant becomes Totally and Permanently Disabled due to a non-occupational or non-auto related injury or Illness while he is Covered by the MCTWF Plan as an Active Participant. Upon your submission of the application for TPD benefits, all rights to the Retiree Medical Program are forfeited.

The Participant is considered Totally and Permanently Disabled if the Trustees determine, based on the evidence satisfactory to them, that he has a physical or mental condition that is expected to continue for the remainder of his life and that causes him to be unable to engage in any regular employment or occupation for compensation, profit or gain for which he may be suited by his education, training or experience.

The Trustees are the sole judge of whether the Participant is Totally and Permanently Disabled and whether he is entitled to a TPD benefit. The Trustees may consider as evidence, but are not bound by, a determination by the Social Security Administration concerning the Participant's eligibility for Social Security Disability Benefits. As part of the Participant's application for TPD benefits, the Trustees may require him to submit to an examination by a Physician or other medical professional selected by the Trustees and to provide evidence of his earnings or compensation.

If the Participant is receiving a TPD benefit, the Trustees may require him to submit to re-examination periodically (but not more often than annually) and to provide evidence of earnings or compensation. If the Participant fails or refuses to submit to an examination or provide earnings or compensation information requested by the Trustees, he will not be entitled to a TPD benefit.

### SEC. 5.1: BENEFIT AMOUNT AND DURATION

If the Participant meets the requirements for a TPD benefit, MCTWF will pay monthly benefits. Payment will start at the beginning of the month after the month in which the Trustees approve payment under this provision. The Participant will receive a monthly benefit for as long as he remains Totally and Permanently Disabled up to his benefit maximum.

If the Participant dies while receiving TPD benefits or has applied and has been approved for TPD benefits but has not yet received his initial check, his Spouse or designated beneficiary will receive the remaining benefits in a single lump-sum payment.

This TPD benefit is intended to provide limited financial assistance to Participants if they have lost, completely and irrevocably, the ability to earn an income. A Participant could, however, at some future date, sufficiently recover from a previous determination of TPD and regain his ability to earn an income. If the Participant begins receiving TPD benefits but regains his ability to earn an income, his eligibility to receive these benefits ends. If a Participant returns to employment with an Employer that contributes to MCTWF, any benefits previously paid under his TPD benefit will reduce the total of future TPD benefits available to him.

MCTWF has the right to recover any TPD benefits a Participant receives after he is no longer eligible for this benefit. MCTWF may recover these overpayments by reducing future benefits the Participant is entitled to receive under his MCTWF Plan.

## PART 6: PRESCRIPTION DRUG BENEFITS

MCTWF provides you with prescription drug coverage for prescription fills by a retail pharmacy of up to a 34 day supply or for a 35-90 day supply, for prescription fills by a mail service pharmacy of up to a 90 day supply, and for prescription fills by a specialty pharmacy of up to a 90 day supply.

### SEC. 6.1: RETAIL (34) AND RETAIL (90) PHARMACY

Your MCTWF Plan pays for the cost of Covered prescription drugs after you pay the Copayment amount for each separate prescription drug order and each refill. CVS Caremark administers the prescription drug program. Once you become eligible for coverage, you will receive a customized CVS Caremark Prescription Benefit Booklet containing detailed pharmacy benefit information, applicable forms, participating pharmacies nearest you, and you will also receive a list of major participating pharmacy chains. You may also visit MCTWF's website to link to the CVS Caremark website to obtain up-to-date listings of Network pharmacy providers.

When you need to purchase prescription drugs, you may go to any pharmacy that has an agreement with CVS Caremark and present your MCTWF Networks Card, which will evidence your coverage and restrictions and provides billing instructions. If you purchase prescription drugs at any non-participating pharmacy, your MCTWF Plan pays for 100% of CVS Caremark's Allowed Amount less the Copayment under your MCTWF Plan.

If there is a Generic Drug equivalent to a Brand Name Drug, your MCTWF Plan pays for only the Generic Drug, unless the prescription order indicates "Dispense as Written" or ("DAW"), in which case you will be responsible for the Brand Name Copayment. If the prescription does not say "DAW" but you request a Brand Name Drug, you will be responsible for the Generic Drug Copayment plus any amount related to the difference in the Allowed Amount between the Generic Drug and the Brand Name Drug. If the prescription is filled with a Brand Name Drug because there is no Generic Drug available, you are responsible for the Brand Name Copayment.

#### 6.1(a) FILLING A PRESCRIPTION AT A RETAIL PHARMACY

You may obtain up to a 90 Day supply of prescription drugs.

To get a prescription filled at a retail pharmacy for up to a 90 day supply, take your written prescription to a participating retail pharmacy and present your MCTWF Networks Card to the pharmacy along with the appropriate Copayment.

### SEC. 6.2: MAIL SERVICE PHARMACY

You can obtain up to a 90 Day supply of Covered prescription drugs through CVS Caremark's mail service prescription drug program. This program offers low cost, convenient mail service (by first class mail or UPS) and pays all necessary postage.

**6.2(a) FILLING A PRESCRIPTION THROUGH THE MAIL SERVICE PHARMACY**

Ask your Physician to write two prescriptions. One prescription should be for up to a 34 Day supply, to fill at a participating retail Network pharmacy to ensure an immediate supply. The other prescription should be for up to a 90 Day supply, plus any appropriate refills. Complete a CVS Caremark *Mail Service Order Form* (available in your CVS Caremark Prescription Benefit Booklet, from the Forms page of MCTWF's website or from the MCTWF Customer Communications Department) and send it to CVS Caremark, along with your original prescription(s) (not a photocopy), and the appropriate Copayment for each prescription. You must mail in a *Mail Service Order Form* each time you request a new prescription through the mail service pharmacy. The mail service pharmacy will process your order and send your medication to you within 14 Days along with re-order instructions for future prescriptions or refills. In addition to ordering your prescription refills by mail, you may also order online at [www.caremark.com](http://www.caremark.com) or by contacting CVS Caremark.

If you have any questions about your medications, you can contact CVS Caremark.

**SEC. 6.3: SPECIALTY PHARMACY SERVICES**

Specialty pharmacy services provide specialty injectable, infusible and oral drugs for individuals with chronic or genetic conditions. Through this service you receive convenient mail delivery of specialty medications, personalized service and educational support for your specific therapy. A team of professionals is assigned to help you successfully manage your condition and improve your quality of life. If you are prescribed a specialty medication and go to a retail pharmacy, the pharmacist will ask you to contact CVS Caremark at 800-237-2767, to initiate your direct relationship with specialty pharmacy services.

Certain medications for the chronic or genetic conditions listed below are included in specialty pharmacy services (which may change or expand from time to time without notice).

- Allergic Asthma
- Crohn's Disease
- Cystic Fibrosis
- Growth Hormone and Related Disorders
- Hematopoietics
- Hereditary Angioedema
- Hormonal Therapies
- Immune Deficiencies and Related Disorders
- Lysosomal Storage Disorders
- Macular Degeneration
- Multiple Sclerosis
- Oncology-Injectable
- Osteoarthritis
- Osteoporosis
- Hemophilia, Von Willebrand Disease and Related Bleeding Disorders
- Hepatitis C
- HIV Medications
- Psoriasis
- Pulmonary Arterial Hypertension
- Pulmonary Disease
- Oncology - Oral
- Renal Disease
- Respiratory Syncytial Virus
- Rheumatoid Arthritis

## **SEC. 6.4: PRESCRIPTION DRUG PRIOR AUTHORIZATIONS**

Certain prescription drug classifications require prior authorization. Have your Physician contact CVS Caremark to obtain authorization for the following medications:

- anabolic steroid prescription drugs;
- anti-obesity prescription drugs;
- attention deficit hyperactivity disorder/narcolepsy prescription drugs (age 20 and above);
- oral acne prescription drugs;
- topical acne prescription drugs (age 26 and above); and
- oral anti-fungal prescription drugs.

## **SEC. 6.5: NON-SEDATING ANTIHISTAMINES AND PROTON PUMP INHIBITORS**

All prescription non-sedating antihistamines and proton pump inhibitors are excluded under the prescription drug benefit, due to the fact that non-sedating antihistamines and proton pump inhibitors are available without prescription (i.e., over-the-counter or OTC).

However, your Physician may request an exemption from this exclusion based on medical necessity by submitting a prior authorization request to the MCTWF Utilization Review Department (see criteria below). You and your Physician will be notified in writing of MCTWF's determination. If authorization is granted, any prescription filled up to four Days prior to the post, fax or email date of the request for prior authorization is eligible for reimbursement in an amount not to exceed CVS Caremark's Allowed Amount less your MCTWF Plan's Copayment.

### **6.5(a) NON-SEDATING ANTIHISTAMINES - CRITERIA FOR AUTHORIZATION**

Authorization is contingent upon -

- a documented failure of treatment (minimum of two week trial) with OTC non-sedating antihistamines;
- an adverse reaction or intolerance to OTC non-sedating antihistamines; or
- an adverse drug interaction or potential adverse drug interaction.

### **6.5(b) PROTON PUMP INHIBITORS - CRITERIA FOR AUTHORIZATION**

Authorization is contingent upon -

- a documented failure of treatment (minimum of 8 week trial) with OTC proton pump inhibitors;
- an adverse reaction or intolerance to OTC proton pump inhibitors; or
- an adverse drug interaction or potential adverse interaction with OTC proton pump inhibitors.

In addition to satisfying one of the above criteria, full coverage for prescribed proton pump inhibitor medications (subject to 90 Day retail or mail order copayments only) are contingent upon the prescribing Physician's documentation of the existence of esophagitis or a complication caused by that condition (e.g., esophageal narrowing, esophageal ulcer, or Barrett's esophagus). Otherwise, coverage is limited to 15% of CVS Caremark's Allowed Amount, except for Generic Omeprazole which is Covered in full, subject to the 90 Day Copayment.

## SEC. 6.6: SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI) STEP THERAPY

SSRIs are a therapeutic class of prescription drugs that are commonly referred to as psychostimulants or antidepressants. MCTWF's SSRI step therapy program requires that if your Physician wishes to place you on a Brand Name SSRI you must first try one Generic SSRI for a minimum period of 60 Days within a 12 month period. If your Physician still wishes to place you on a Brand Name SSRI, you must receive prior authorization by contacting CVS Caremark. If you satisfy the requirement and commence use of a Brand Name SSRI, you will remain eligible without limitation for the duration of treatment. If you wish to resume SSRI treatment after a lapse of one year, you will be subject to the one Generic SSRI trial and prior authorization requirement before obtaining approval for coverage of a Brand Name SSRI.

## SEC. 6.7: PRESCRIPTION DRUG LIMITATIONS

Certain drug categories under your MCTWF Plan have quantity limitations. These limitations may change if your Physician obtains prior authorization, or may otherwise change from time to time without notice. They are as follows:

- erectile dysfunction tablets - such as Caverject®, Edex®, Muse®, Levitra® and Cialis® at a quantity limit of six every 34 days at retail and 20 every 90 days at retail (90) and mail service, regardless of strength;
- influenza treatment and preventions - such as Relenza® tablets, Tamiflu® 75mg tablets and Tamiflu® suspension at a treatment quantity of one every six months at retail, retail (90) and mail service;
- smoking cessation - a maximum continuous drug therapy for any prescription drug is limited to coverage for 180 Days per a 12 month period and a lifetime maximum of two Years of therapy; and
- other limitations - Prostin VR® is Covered through age two, Elidel® is Covered for ages three and over and Protopic® is Covered for ages three and over.

## SEC. 6.8: PRESCRIPTION DRUG REIMBURSEMENT

Under certain circumstances, you may have to pay a pharmacy directly for the full cost of your prescription drugs. The following reflects the circumstances under which MCTWF will reimburse incurred expenses for prescription drugs and the level of such reimbursement:

- when eligibility is established retroactively after a prescription is filled through no fault of yours, you will be reimbursed 100% of charges, less the applicable Copayment;
- when a prescription is filled prior to establishing COBRA continuation coverage, you will be reimbursed the CVS Caremark Allowed Amount determined to be appropriate, less the applicable Copayment;
- when you fill a prescription that is rejected, but is subsequently approved pursuant to MCTWF's Medical Director review, you will be reimbursed the CVS Caremark Allowed Amount determined to be appropriate, less the applicable Copayment;
- when you fill a compound prescription that is rejected and subsequently approved pursuant to CVS Caremark's review, you will be reimbursed the CVS Caremark Allowed Amount determined to be appropriate, less the applicable Copayment; and

- when you fill a prescription at a non-participating (Out-of-Network) pharmacy, you will be reimbursed the amount determined by CVS Caremark to be appropriate, less the applicable Copayment.

When submitting a request for reimbursement of a prescription, you must fill out a CVS Caremark *Prescription Drug Claim Form* available on MCTWF's website or in your CVS Caremark Prescription Benefit Booklet, along with an itemized receipt.

## **SEC. 6.9: PRESCRIPTION DRUG EXPENSES NOT COVERED**

Your prescription drug benefit does not cover the following items:

- charges for any take-home drugs (for example, drugs brought home after out-patient surgery);
- any charges for therapeutic devices or appliances, regardless of their intended use;
- drugs or medicines supplied to the individual by a prescribing Physician or dentist;
- cosmetic or beauty aids, and diet supplements;
- immunizing agents, injectables, blood or blood plasma or medication prescribed for parenteral administration, except insulin and insulin syringes;
- existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are Experimental in nature or any drug labeled "Caution: Limited by Federal Law to Investigational Use";
- any charge for administration of Covered drugs;
- any charge for prescription refills in excess of the number of refills specified by your Physician or dentist, or any refill dispensed after one year from the date of the original prescription;
- the charge for any medication you are entitled to receive without charge from any municipal, state or federal program, whether contributory or not, except for Medicaid;
- medications that are not FDA-approved and that have not been proven effective for the conditions for which they are being used;
- charges for a Brand Name SSRI prescription drugs without first satisfying the SSRI step therapy requirement;
- charges for non-sedating antihistamine prescription drugs without first receiving prior authorization;
- charges for proton pump inhibitor prescription drugs without first receiving prior authorization;
- charges for anabolic steroid prescription drugs without first receiving prior authorization;
- charges for anti-obesity prescription drugs without first receiving prior authorization;
- charges for attention deficit hyperactivity disorder prescription drugs without first receiving prior authorization;
- charges for oral acne prescription drugs without first receiving prior authorization;
- charges for topical acne prescription drugs (age 26 and above) without first receiving prior authorization;
- charges for oral anti-fungal prescription drugs without first receiving prior authorization;
- charges for medications that exceed the limitations listed on page 52, Sec. 6.7, Prescription Drug Limitations;
- drugs that cost less than your Copayment;
- refills not authorized by a Physician; and
- any expenses shown in General Exclusions and Limitations listed on page 1.

## SEC. 6.10: NOTICE OF CREDITABLE COVERAGE - ALL TIF, SOA, KEY, I&S AND PEP PLANS

The following is published in accordance with regulations promulgated by the Centers for Medicare and Medicaid Services, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003:

Please read this carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCTWF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug Plan. If you are considering joining, you should compare your current coverage, including which drugs are Covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is provided below. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage -

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCTWF has determined that the prescription drug coverage offered by the above stated plans is, on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug Plan.

You can join a Medicare drug Plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug Plan.

If you decide to join a Medicare drug Plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF prescription drug coverage will be primary and your Medicare prescription drug Plan will be secondary. If you are a COBRA continuation coverage beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug Plan. However, you will not be eligible to get your MCTWF COBRA continuation coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug Plan coverage. You should compare your current coverage, including which drugs are Covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug Plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for non-sedating antihistamines, proton pump inhibitors, selective serotonin reuptake inhibitors, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), oral acne, topical acne (age 26 and above) and oral anti-fungal drugs with both retail and mail order availability, subject to Generic and Brand copayments, as detailed in your SPD Booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug Plan.

You should also know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug Plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug Plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact MCTWF's Customer Communications Department. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug Plan, and if this coverage through MCTWF changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage -

- visit [www.medicare.gov](http://www.medicare.gov);
- call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; or
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or you call them at 800-772-1213 (TTY 800-325-0778).

**Remember:** Keep this Notice of Creditable Coverage. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not are not required to pay a higher premium (a penalty).

## PART 7: DENTAL BENEFITS

### SEC. 7.1: CHOICE OF DENTAL PROVIDERS

You have a choice between receiving services from Network or Out-of-Network providers. The option you choose determines how you will receive your dental benefits.

The in-network option gives you the widest scope of coverage. However, you must use the specific dental providers who have chosen to become Delta Dental of Michigan's Delta Dental Premier or Delta Dental PPO Network providers.

Your MCTWF Plan has entered into an arrangement with Delta Dental of Michigan. Delta Dental Premier and Delta Dental PPO Network providers are obligated to accept agreed upon fees as payment in full for services. Therefore, when services are rendered by dentists within either Network, you are responsible for paying your Coinsurance amount, where applicable, or any amount in excess of your Annual per person maximum. You also are responsible for procedures that are not Covered.

The Out-of-Network option provides MCTWF Plan benefits subject to higher out-of-pocket costs, but allows you to use the dental provider of your choice. Because MCTWF does not have a fee arrangement with Out-of-Network dentists, they may charge whatever they want and may expect to receive total payments equal to their charge. If the fees of Out-of-Network providers are greater than the amounts paid under your MCTWF Plan's Out-of-Network Maximum Allowable Benefit schedule, you will be responsible for paying the balance or the full amount if you have reached your Annual per person maximum. When you use Out-of-Network providers, you are subject to paying any balance over and above the Maximum Allowable Benefit schedule.

MCTWF is required to furnish you automatically and without charge a list of its Network of dental providers. This listing is referred to as the participating provider directory. You may also visit MCTWF's website to link to the Delta Dental website to obtain up-to-date lists of Network dental providers.

### SEC. 7.2: PREDETERMINATION OF BENEFITS

Predetermination of benefits allows you to know what benefits your MCTWF Plan pays for before the actual dental work is performed. You will then be able to determine the difference, if any, that you may have to pay yourself.

Your dentist or dental specialist may submit a treatment plan for review by Delta Dental of Michigan before any dental procedures are performed. In order to ensure that intended dental services are Covered under your MCTWF Plan and to ensure that you understand any financial exposure you may have, MCTWF recommends predetermination of all dental services in excess of \$200 in charges.

#### 7.2(a) OBTAINING A PREDETERMINATION OF BENEFITS

To obtain a predetermination of benefits, have your dentist fill out a claim form or electronically submit a claim form directly to Delta Dental of Michigan showing the proposed treatment and costs. You may obtain a claim form from MCTWF by calling the Customer Communications Department or from the Forms page of MCTWF's website.

Both you and your dentist will receive a statement of predetermination showing the amount that your MCTWF Plan pays for the dental procedure. Generally, this amount will only be paid if you receive the treatment within 90 Days of the date of the predetermination.

### **SEC. 7.3: ALTERNATE PROCEDURES**

In some cases, there is more than one way to treat a dental problem. Your MCTWF Plan pays for both in-network and Out-of-Network benefits based on the procedure that will provide a professionally acceptable result as determined by national standards of dental care, in a cost-effective manner.

### **SEC. 7.4: COVERED DENTAL EXPENSES**

There are four classes of dental services under MCTWF's Plan of benefits. They are -

Class I - diagnostic and preventive services.

Class II - basic restorative services.

Class III - major restorative services.

Class IV - orthodontic services.

Your Coinsurance amount is based on the class of service you receive.

Class I Covered dental services include -

- oral examination, prophylaxis (cleanings) twice per calendar year;
- full mouth x-rays every five Years per dental specialty;
- bitewing x-rays twice per calendar year;
- laboratory and diagnostic tests;
- fluoride treatments twice per calendar year for Dependents up to age 14;
- brush biopsy test;
- emergency palliative treatment;
- space maintainers;
- sealants for first and second permanent molars of Dependent children up to age 14 with high risk teeth. A child with high risk teeth is one who has had dental caries in one or more permanent molars. A 25% Coinsurance charge applies. This service must be prior authorized by the provider by submitting a written request to MCTWF's Utilization Review Department; and
- repair or reapplication of Dependent child sealants beyond three Years from the sealant application date. A 25% Coinsurance charge applies. This service must be prior authorized by the provider by submitting a written request to MCTWF's Utilization Review Department.

Class II Covered dental services and supplies include -

- oral surgery;
- endodontics;
- extractions, root canals and fillings;
- periodontics;
- periodontal scaling/root planning once, per quadrant, in any consecutive 24-month period;
- amalgam/resin restoration once in any consecutive 24-month period; and
- periodontal surgery, including subgingival curettage, once in any consecutive 36-month period.

Class III Covered dental services and supplies include -

- onlays, crowns, bridgework, dentures and other prosthetics;
- reline or complete replacement of denture base material once in any three-year period per appliance; and
- implants.

Class IV Covered orthodontic services are subject to the following rules:

- in-network orthodontic services are Covered up to your lifetime benefit maximum;
- for Dependent children under age 19, Out-of-Network orthodontic services are Covered up to their lifetime maximums;
- orthodontic treatment occasionally requires more than one phase. All phases are applied towards your lifetime benefit maximum. Your MCTWF Plan continues to pay for benefits as long as you remain Covered and eligible under your MCTWF Plan; and
- if your coverage ceases during a calendar quarter, payment for services will be made for the calendar quarter you were last Covered for.

#### **7.4 (a) COVERED DENTAL EXPENSES FOR HIGH RISK MEDICAL CONDITIONS**

Your MCTWF Plan pays for the following expanded dental preventative services for Covered individuals with certain high risk medical conditions:

- for diabetics with periodontal disease, pregnant women with periodontal disease, individuals with kidney failure or who are undergoing dialysis, those with suppressed immune systems due to chemo or radiation therapy, those with HIV, or those who have had organ or bone marrow transplants, the MCTWF Plan pays for four teeth cleanings per calendar year, either routine or periodontal;
- for those individuals, regardless of age, undergoing head and neck radiation treatment, the MCTWF Plan pays for two fluoride applications per calendar year; and
- for Covered individuals with certain heart conditions, the MCTWF Plan pays for four teeth cleanings per calendar year, either routine or periodontal, subject to Annual benefit maximums. These heart conditions are -
  - a history of infective endocarditis;
  - certain congenital heart defects (such as having one ventricle instead of the normal two);
  - artificial heart valves;
  - heart valve defects caused by acquired conditions like rheumatic heart disease;
  - hypertropic cardiomyopathy;
  - pulmonary shunts or conduits; or
  - mitral valve prolapse with regurgitation (blood leakage).

The dentist is responsible for submitting appropriate documentation of the existence of such condition in order for the claim for additional cleanings to be Covered.

#### **7.4(b) COVERED DENTAL EXPENSES AFTER ELIGIBILITY CEASES**

The following dental services that commenced, but were not completed, prior to the loss of eligibility are paid for if completed within 60 Days of the date that treatment started:

- the completion of dentures (full or partial) if the impression was made prior to the loss of eligibility;
- the completion of fixed bridgework, restorations and crowns if the tooth or teeth were prepared prior to the loss of eligibility; and
- the completion of root canal therapy if the tooth or teeth were opened for treatment prior to the loss of eligibility.

Dental claims for these services initially will be denied. To have the claim reconsidered, the dentist then must resubmit the claim with a copy of your chart to document that the date the treatment commenced was prior to the loss of your eligibility.

### **7.4(c) OUT-OF-NETWORK SERVICES**

If you choose to obtain dental services from an Out-of-Network provider, Covered services are paid according to a Maximum Allowable Benefit schedule. In most cases dental benefits are generally paid to you directly when you use an Out-of-Network provider, regardless of whether that provider accepts an assignment of your benefits. You will be responsible for paying any difference between the cost of the services and the Amount Paid by your MCTWF Plan. It is your responsibility to make payment in full to your dental provider.

## **SEC. 7.5: IF YOU DO NOT HAVE ACCESS TO NETWORK GENERAL DENTISTS OR ORTHODONTIC PROVIDERS**

In the event you live further than 20 driving miles (as determined by MCTWF) from a Network general dentist, you will have the option of seeking care from a dentist of your choice. Please note that dental specialists, are not Covered. To obtain such exemption, you must apply utilizing an MCTWF *Non-Access Exemption Application*. Authorization to use an Out-of-Network provider will be determined on a per application basis and will continue for six months from the date that the first Out-of-Network services are rendered.

Similarly, in the event you live further than 25 driving miles (as determined by MCTWF) from a Network orthodontist, you will have the option of seeking care from an orthodontist of your choice. To do so, you must apply for an exemption to use an Out-of-Network provider (see page 59, Sec. 7.5, If You Do Not Have Access to Network General Dentists or Orthodontic Providers). To obtain such exemption, you must apply utilizing a *Non-Access Exemption Application*. Authorization to use an Out-of-Network provider will be determined on a per application basis and will continue for the length of the treatment.

Authorized Out-of-Network services are subject to the same Coinsurance and benefit maximums that apply to in-network services. Payment generally will be made directly to you, not your Out-of-Network dentist. However, you will be responsible for payment in full to the provider, including any amounts in excess of Delta Dental of Michigan's Allowed Amount, as well as any amounts in excess of your Annual or lifetime limits.

### **7.5(a) NON-ACCESS EXEMPTION APPLICATION**

To be accepted, your application must be received by MCTWF within 60 Days following the receipt of Out-of-Network services. If your application is approved, the claim will be deemed as Out-of-Network and all applicable Coinsurance and benefit maximum amounts will apply. Once your application to use an Out-of-Network general dentist is approved, the approval will continue for six months from the date that the first Out-of-Network services are rendered. In the case of orthodontic services, that approval will continue through the length of treatment. Any services beyond the treatment period must be authorized pursuant to the submission and approval of a new application. You may obtain an MCTWF *Non-Access Exemption Application* form, by calling MCTWF's Customer Communications Department or from MCTWF's website.

## SEC. 7.6: DENTAL EXPENSES NOT COVERED

In addition to the items shown in the General Exclusions and Limitations section of your SPD Booklet, the following types of dental services and care are not Covered by your MCTWF Plan:

- appliances, restorations or services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ). This may be Covered under your MCTWF medical benefits Plan;
- treatment given by anyone who is not a licensed dentist or dental practitioner, except charges for dental prophylaxis performed by a dental hygienist under the supervision and direction of a dentist;
- temporary restoration;
- charges for sealants, except for first and second permanent molars of Dependent children up to age 14 with high risk teeth and with prior authorization. High risk means teeth which have caries (tooth decay) in one or more molars;
- repair or reapplication of sealants for Dependent children within three Years from the sealant application date;
- charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
- procedures, services or supplies that are Experimental in nature;
- procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, or for increasing vertical dimension, splinting or replacing tooth structure lost as the result of abrasion or attrition;
- drugs, medicaments, prescriptions, other than the injection of antibiotics;
- inlays;
- charges made by a Hospital;
- expenses for root canal treatment and/or apicoectomies when previously paid;
- expenses for services or appliances started before the effective date of coverage under your MCTWF Plan;
- expenses for replacement made less than five Years after placement or replacement that was Covered by your MCTWF Plan including crowns, onlays, substructures (including pins, posts, cores and thimbles), fixed bridges, removable prosthetic appliances and complete occlusal adjustment;
- limited occlusal adjustment not more than three times in a five year period;
- general anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary;
- benefits or services that are available from any government agency, political subdivision, community agency, foundation, mutual benefit association, labor Union trust or similar group or any similar entity;
- expenses for extension of bridges or prosthetic devices previously paid for by your MCTWF Plan incurred in new extended areas;
- orthodontic expenses for those over age 19, if provided by an Out-of-Network provider;
- orthodontic expenses for Participants and Spouses under age 19, if provided by an Out-of-Network provider;
- services or supplies received as a result of dental disease or injury due to an act of war, declared or undeclared;
- expenses for mouth guards and associated devices;

- services as determined by MCTWF for cosmetic surgery or dentistry for aesthetic reasons;
- any expenses incurred that exceed the dental/orthodontia services Annual and/or lifetime maximums;
- porcelain, porcelain substrate, and cast restorations for Dependent children less than 12 years of age;
- fixed bridges and removable cast partials for Dependent children less than 16 years of age;
- oral examination, prophylaxis (cleaning) more than two times per calendar year, except for high risk medical conditions (see page 58, Sec. 7.4(a), Covered Dental Expenses for High Risk Medical Conditions);
- bitewing x-rays more than two times per calendar year;
- full mouth or panoramic x-rays more than once in a five year period per dental specialty, except when there is adequate evidence that an additional x-ray is clinically necessary;
- fluoride treatments for Dependents up to age 14 more than two times per calendar year;
- fluoride treatment for Dependents age 14 and over;
- reline or complete replacement of denture base material more than once in any three-year period per appliance;
- cosmetic services including teeth whitening; or
- all porcelain composition crowns seated in the posterior portion of the mouth.

## PART 8: VISION BENEFITS

### SEC. 8.1: CHOICE OF VISION PROVIDERS

You have a choice between receiving services from Network or Out-of-Network vision providers. The option you choose determines how you will receive your vision benefits.

The in-network option may result in full coverage of your vision services and products and if not, it will result in less out of pocket expense. However, you must use the specific vision providers who have chosen to become DeltaVision Network providers.

The Out-of-Network option allows you to use the vision provider of your choice.

MCTWF is required to furnish you automatically and without charge a list of its Network of vision providers. This list is referred to as the participating provider directory. You may also visit MCTWF's website to link to the DeltaVision website to obtain an up-to-date list of Network vision providers.

### SEC. 8.2: IN-NETWORK OPTION

The in-network option provides you coverage as follows:

- coverage in full for eye examinations and basic glass or plastic single, bifocal and trifocal lenses;
- coverage in full for polycarbonate lenses for Dependent children under age 18;
- coverage up to fixed dollar amounts for frames, progressive lenses, contact lenses and laser vision correction;
- a 15% discount off the provider's lowest available retail price in addition to the in-network Allowed Amount for frames, progressive lenses, and other lenses (e.g., high index, aspheric, wavefront, photochromic, polarized); and
- a 15% discount off the provider's lowest available retail price for lens coatings (e.g., scratch resistant, ultra violet, tinted, anti-reflective).

Your MCTWF Plan pays for benefits based on a per lifetime limit for laser vision correction and an Annual limit for all other services. However, if you receive laser vision correction services you are not entitled to coverage for frames, eyeglass lenses or contact lenses during that calendar year.

When using a Network provider, you need to inform him that your MCTWF Plan uses DeltaVision. You will be asked to provide the Participant's social security number for eligibility and billing purposes.

### SEC. 8.3: OUT-OF-NETWORK OPTION

The Out-of-Network option allows you to choose any licensed provider but will generally result in less coverage. You will remain responsible for any balance in excess of the Allowed Amount.

## **SEC. 8.4: VISION EXPENSES NOT COVERED**

In addition to the items shown in the General Exclusions and Limitations section of your SPD Booklet, your MCTWF Plan does not pay for the following types of vision services:

- services or supplies to correct a vision defect that happens as the result of a work-related or auto-related injury or illness;
- services or supplies received from a vision department maintained by a mutual benefits association, labor Union or other similar group;
- vision services or supplies received more frequently than allowed;
- treatment given by someone who is not a licensed optometrist, ophthalmologist or optician;
- any service or procedure not specifically included or exceed limits stated in the Schedule of Benefits;
- the charges for polycarbonate lenses in excess of the Allowed Amount for basic lenses, for anyone age 18 and over;
- sunglasses, plain or prescription, or safety lenses or goggles, tinting or photochromic lenses;
- any lens coating including scratch resistant, ultra violet, tinted or anti-reflective;
- procedures, services or supplies that are Experimental in nature;
- orthoptics, vision training or aniseikonia; or
- repairs of any kind.

Services within an optometrist's licensed scope of treatment that meet MCTWF's medical necessity criteria, whether using a Network or Out-of-Network provider, may be reimbursed as a medical benefit; the diagnoses and services billed will determine whether eligible claims will be reimbursed as a medical or vision benefit.

## PART 9: ACTIVE DEATH BENEFITS

### SEC. 9.1: EMPLOYEE DEATH BENEFIT

If you die while you are an eligible Employee, as defined in this SPD Booklet, your beneficiary is entitled to a death benefit subject to the following limitations:

- your beneficiary is not entitled if you die while you are receiving total and permanent disability benefits, COBRA continuation coverage, extended disability benefits, or when incurred during benefit bank weeks;
- death benefits for death by suicide will not be paid unless you have been actively and consecutively Covered under your MCTWF Plan for a period of 24 or more months. If you finish work for one work week and die during the following work week in the gap period prior to your scheduled return to work, your death benefit is payable; and
- for death due to Illness of first year Participants, the benefit amount is limited to that contained in the MCTWF package Plan from which the medical benefit derives. This limitation affects only those Covered under an MCTWF cafeteria Plan with increased death benefits, and does not apply if the death is Accidental.

Beneficiary designations must be in writing and filed with MCTWF. You may name anyone you wish as your beneficiary by completing your MCTWF *Enrollment Card*. If you designate a beneficiary who is a minor, MCTWF can only pay the death benefit to a guardian or conservator with full authority to access, receive and dispose of the named minor's assets, as so appointed by Order of the Probate Court. You can change your beneficiary at any time by completing and signing an MCTWF *Change of Beneficiary Form* provided by MCTWF by contacting MCTWF's Customer Communications Department or on the Forms page of MCTWF's website.

### SEC. 9.2: DEPENDENT DEATH BENEFIT

MCTWF provides death benefits for your Spouse and your Dependent children under age 19. A benefit is payable to you if a Dependent dies from natural or Accidental causes. Death benefits for a Dependent's death by suicide will not be paid unless the Participant has been actively and consecutively Covered under your MCTWF Plan for a period of 24 or more months.

### SEC. 9.3: HOW YOUR PLAN PAYS BENEFITS

Your death benefit will be paid to the beneficiary or beneficiaries named by you. If you name more than one beneficiary but do not specify the percentage of your benefit that each should receive, all beneficiaries will receive equal amounts. If a beneficiary dies before you, her interest will pass to the surviving beneficiary or beneficiaries.

Benefits will be paid according to the most recent listing of your beneficiaries on your MCTWF *Enrollment Card* or *Change of Beneficiary Form*. It is important you review your beneficiary designation when there is a change in your family status.

If you name your Spouse as your beneficiary on your *Enrollment Card* or *Change of Beneficiary Form* and you and your Spouse are later divorced, death benefits will be paid to your former Spouse at your death unless you change your beneficiary designation.

If you don't name a beneficiary or if you have no surviving beneficiary, benefits will be paid to your estate. You are automatically designated as the beneficiary for your Spouse and Dependent children.

## PART 10: ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental death and dismemberment (AD&D) benefits are paid if the Participant dies or is seriously injured as a result of an Accident. AD&D benefits may be paid in addition to Active death benefits, but not in addition to Retiree Death Benefit Program benefits.

If the Participant dies or suffers a loss within 90 Days after an Accidental Injury, he or his beneficiaries will receive benefits as follows:

Event	Benefit	Who Receives Benefit
If Participant dies	100% of benefit maximum	Participant's Beneficiary
Participant's loss of both hands or feet	100% of benefit maximum	Participant
Participant's loss of the sight of both eyes	100% of benefit maximum	Participant
Participant's loss of one hand and one foot	100% of benefit maximum	Participant
Participant's loss of one hand and the sight of one eye	100% of benefit maximum	Participant
Participant's loss of one hand or one foot	50% of benefit maximum	Participant
Participant's loss of the sight of one eye	50% of benefit maximum	Participant

Accidental death and dismemberment benefits are not available to the Participant's Dependents.

If the Participant incurs more than one loss due to an Accidental Injury, only one benefit, the highest, will be paid as the result.

### SEC. 10.1: WHEN BENEFITS ARE NOT PAYABLE

The accidental death and dismemberment benefit does not cover losses caused by -

- illness, whether physical or mental, or medical or surgical treatment;
- ptomaine, or bacterial infections, except infection caused by a visible wound resulting from an injury;
- suicide while sane or insane, or any intentionally self-inflicted injury;
- death as the result of the deceased Participant's impaired conduct, of whatever nature, caused by the voluntary or involuntary use of alcohol beyond the legal limit for operation of a motor vehicle, or misuse of drugs;
- war, or any act of war, whether declared or undeclared;
- an insurrection or participation in a riot;
- commission of a crime; or
- losses occurring 90 Days beyond the date of the Accidental Injury that resulted in the loss.

## PART 11: RETIREE DEATH BENEFIT PROGRAM

The Retiree Death Benefit Program provides death benefits for Retiree Medical Program Retirees and their Spouses. Eligible Retirees and their Spouses individually may choose the amount of death benefit each wishes to have, from \$1,000 up to \$10,000.

### SEC. 11.1: HOW THE PROGRAM PAYS BENEFITS

Benefits will be paid according to the most recent listing of your beneficiaries on an MCTWF *Retiree Death Benefit Program Election Form* or *Change in Beneficiary Form*, whichever is most recent. It is important that you review your beneficiary designation when there is a change in your family status.

The benefit payable under the Retiree Death Benefit Program for a death within one year after the commencement of coverage is limited to the amount of Contributions received by MCTWF for coverage of the deceased Retiree or Spouse. This limitation does not include a death resulting from an Accidental Injury.

The benefit payable under the Retiree Death Benefit Program for a death by suicide within two Years after the commencement of coverage is limited to the amount of Contributions received by MCTWF for coverage of the deceased Retiree or Spouse.

### SEC. 11.2: TERMINATION OF COVERAGE

Coverage under the Retiree Death Benefit Program for a Retiree or Spouse will cease upon the first to occur of the following events:

- date the Retiree dies, or, for Spouse coverage, the date the Spouse dies;
- failure to file a Contribution within the time required; or
- the date of termination of the Retiree Death Benefit Program as determined by the Trustees or an amendment to the Retiree Death Benefit Program eligibility requirements by the Trustees that make the Retiree or Spouse no longer eligible for coverage under the Retiree Death Benefit Program.

## PART 12: FLEXIBLE DEPENDENT COVERAGE PROGRAM

The Flexible Dependent Coverage Program provides a health reimbursement account to cover certain medical, dental and vision expenses for you that are not reimbursed by MCTWF or other group health plans and that are deductible from an individual tax return if itemized (pursuant to section 213(d) of the Internal Revenue Code).

To participate in the Flexible Dependent Coverage Program, any Dependents you have must have other group health coverage. You must waive Dependent coverage for all medical, and prescription drug benefits for your Dependents under your MCTWF Plan. Your Dependents will be eligible for all other benefits under your MCTWF Plan. Enrollment in the Program remains in effect for the calendar year unless you have a change in family status.

### SEC. 12.1: HEALTH REIMBURSEMENT ACCOUNT CREDITS

If you decide to participate in the Flexible Dependent Coverage Program and waive your Dependent medical and prescription drug coverage under your MCTWF Plan, a health reimbursement account will be established on your behalf. For each full calendar month you are Covered under MCTWF (i.e., by virtue of payment of required Contributions, benefit bank weeks, weekly accident and sickness benefits or eligible strike or lockout), \$100.00 per month will be credited to your account. For “grandfathered” (see page 13, Sec. 2.1(n), Flexible Dependent Coverage Program) Participants with no Dependents, for each full calendar month you are Covered under MCTWF, \$45 per month will be credited to your account. Any sums not used for reimbursement of eligible expenses incurred in a calendar year will be forfeited. Partial months of eligibility do not count toward your monthly account credit.

#### 12.1(a) EXPENSES ELIGIBLE FOR REIMBURSEMENT UNDER YOUR FLEXIBLE DEPENDENT COVERAGE PROGRAM

Generally, eligible expenses are your medical, dental and vision expenses that are not reimbursed by other group health plans and that you could deduct from your individual tax return if you itemized your deductions.

Eligible expenses are -

- abortion;
- acupuncture;
- alcoholism treatment;
- ambulance service;
- artificial limbs;
- artificial teeth;
- birth control pills;
- Braille books and magazines;
- breast reconstruction surgery following mastectomy;
- mastectomy bras that exceed the two allowable per calendar year;
- 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;

- Contribution copayments for an MCTWF Plan that are paid on a post-tax basis;
- Copayments and Deductible paid under this MCTWF Plan and other benefit plans;
- crutches;
- dental treatment;
- diagnostic tests;
- diagnostic imaging;
- disabled Dependent care;
- Doctor's fees;
- duplicate prosthetic devices;
- drug addiction inpatient treatment;
- drugs requiring a prescription;
- eyeglasses;
- eye surgery;
- fertility enhancement;
- guide dogs or other service animal;
- health institute treatment prescribed by a Physician;
- hearing aids and examinations;
- hearing treatment;
- Hospital services;
- insulin;
- 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 (i.e., 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 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;
- nursing home services (Medically Necessary);
- nursing services;
- operations (i.e., medical expenses you pay for operations that are not medically unnecessary cosmetic surgeries);

- optometrist's fees;
- organ transplants;
- osteopath;
- oxygen;
- periodontal fees;
- prostheses;
- psychiatric care;
- psychoanalysis;
- psychologist;
- psychotherapy (by approved provider);
- special schools for the handicapped;
- sterilization (i.e., legally performed surgery for the purpose of making a person unable to have children);
- smoking cessation programs (does not include non-prescription drugs such as nicotine gum and patch);
- surgery;
- telephone for the deaf;
- television equipment for hearing impaired;
- therapy received as medical treatment;
- transplant donor expenses;
- transportation for medical care;
- tuition (i.e., medical expense charges for medical care included in tuition of a college/private school);
- vasectomy;
- vitamins requiring a prescription;
- vision correction surgery (such as LASIK or radial keratotomy);
- weight-loss program - if prescribed by Physician with respect to specific disease (includes group fees; does not include dues for gym, health club, or spa; does not include diet food or beverage unless food does not satisfy normal nutritional needs, food alleviates or treats an illness, and need for the food is substantiated by a Physician);
- wheelchair or autoette; and
- wig purchased upon the advice of a Physician.

### **12.1(b) EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT**

Expenses not eligible for your reimbursement account include but are not limited to -

- 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;
- hair transplant;
- household help;
- illegal operations and treatments;
- health club dues;
- maternity clothes;
- meals and lodging away from home for medical treatment not received at a medical facility;
- medical savings account Contributions or distributions;
- 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; or
- weight-loss programs even 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.

## **SEC. 12.2: REIMBURSEMENT PROCEDURES**

All claims (including prescriptions) must be processed by MCTWF and/or other group health plans before you submit them for reimbursement under this Program. You must submit proof that you have paid any balances remaining after the other group health plan has made its payment. Reimbursement from your health reimbursement account will be made directly to you.

Reimbursement from your account can be made up to twice yearly depending upon whether you choose to make semi-annual or Annual submissions for reimbursement, as follows:

- in order to qualify for reimbursement of eligible expenses incurred during the first six months of the calendar year you must submit them between July 1st and August 31st; and
- for reimbursement of expenses during the second half of the calendar year or all eligible expenses incurred during the entire calendar year you must submit them between January 1st and March 31st.

Reimbursement is based upon the date you pay for the services and not on the date of the service. For example, if service was rendered to you in December 2009 but it was not paid for until January 2010, the expense is considered an eligible expense for the year 2010 under your MCTWF Plan.

When you request reimbursement from your account, you must submit an MCTWF *Flexible Dependent Coverage Program Claim Form* along with your paid receipts, rejections or proof that the other group health plan has paid its maximum benefits. All receipts must reflect payment in full, must contain a written description of the service/expense, must be a qualified service/expense and must not be an expense reimbursable by another policy or Plan. You may call MCTWF's Customer Communications Department for additional *Flexible Dependent Coverage Program Claim Forms*, or obtain one from MCTWF's website.

Sums credited to your account may be used only for expenses that you incur during periods in which you -

- are eligible under your MCTWF Plan; and
- participate in the Flexible Dependent Coverage Program.

Sums credited to your account will be forfeited if reimbursement is not requested before April 1st of the year following the year in which you incurred the eligible expenses.

## PART 13: HOW TO FILE A CLAIM

If you use Network providers, they will file claims and will be paid pursuant to contract. If your Out-of-Network provider requests a claim form, it is available by calling MCTWF's Customer Communications Department or from the Forms page of MCTWF's website. To check on the status of your claim, you may contact MCTWF's Customer Communications Department or through MCTWF's Participant Web Portal.

### SEC. 13.1: CLAIMS FOR MEDICAL BENEFITS

All medical service providers, BCBS PPO Network or non-BCBS PPO Network, must bill the local BCBS Plan. If an Out-of-Network provider does not accept an assignment of your benefits and you pay directly for services, you may submit the paid receipt to MCTWF with a claim form for appropriate reimbursement.

### SEC. 13.2: CLAIMS FOR WEEKLY ACCIDENT AND SICKNESS BENEFITS

You must submit an MCTWF *Participant's Report of Disability* claim form to MCTWF for weekly accident and sickness benefits, which can be obtained by contacting MCTWF's Customer Communications Department or on the Forms page of MCTWF's website. You must complete the section of the form entitled "Participant Information," your Doctor must complete the "Physician's Statement" portion of the form and your Employer must complete the section called "Employer's Statement."

When you receive your benefit check, if you are near your return to work date but are still disabled, you will also receive another *Participant's Report of Disability* claim form. You, your Doctor and your Employer must complete the form and submit it to MCTWF to verify your continuing eligibility and ensure that you continue receiving benefit payments.

### SEC. 13.3: CLAIMS FOR TOTAL AND PERMANENT DISABILITY BENEFITS

If you become Totally and Permanently Disabled, in order to apply for a total and permanent disability benefit you must file an MCTWF *Total and Permanent Disability Benefit* claim form. Copies must be completed by you, your Physician and your Employer.

### SEC. 13.4: CLAIMS FOR PRESCRIPTION DRUG BENEFITS

Under certain circumstances, you may find it necessary to pay a pharmacy directly for the full cost of your prescription drugs. The following lists the circumstances under which MCTWF will reimburse incurred expenses for prescription drugs and the level of such reimbursement:

Circumstance	MCTWF Level of Reimbursement
MCTWF Plan eligibility established retroactively after prescription filled through no fault of the Participant (e.g., Copayment is not received timely from a newly Contributing Employer).	Reimburse 100% of charges, less the applicable Copayment.
Prescription filled prior to establishing COBRA continuation coverage.	Reimburse the amount determined by CVS Caremark to be appropriate, less the applicable Copayment.

<b>Circumstance</b>	<b>MCTWF Level of Reimbursement</b>
Prescription filled that is rejected by CVS Caremark, but is subsequently approved pursuant to MCTWF's Medical Director Review.	Reimburse the amount determined by CVS Caremark to be appropriate, less the applicable Copayment.
Compound prescription filled that is rejected by CVS Caremark and subsequently approved pursuant to CVS Caremark review.	Reimburse the amount determined by CVS Caremark to be appropriate, less the applicable Copayment.
Prescription filled at a non-participating (Out-of-Network) pharmacy.	Reimburse the amount determined by CVS Caremark to be appropriate, less the applicable Copayment.

In order to receive reimbursement you must fill out a claim form and provide to MCTWF a pharmacy receipt. You may obtain a claim form from your CVS Caremark Prescription Benefit Booklet, by contacting MCTWF's Customer Communications Department or from the Forms page of MCTWF's website.

### **SEC. 13.5: CLAIMS FOR DENTAL BENEFITS**

All Delta Dental of Michigan Premier and PPO providers may submit their claims to MCTWF. If an Out-of-Network provider does not accept an assignment of your benefits and you pay directly for services, you may submit the paid receipt to MCTWF with a claim form for appropriate reimbursement.

### **SEC. 13.6: CLAIMS FOR VISION BENEFITS**

All DeltaVision providers may submit their claims to MCTWF. If an Out-of-Network provider does not accept an assignment of your benefits and you pay directly for services, you may submit the paid receipt to MCTWF with a claim form for appropriate reimbursement.

### **SEC. 13.7: CLAIMS FOR ACTIVE DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT, AND RETIREE DEATH BENEFIT PROGRAM BENEFITS**

In the event of a death or dismemberment, MCTWF's Customer Communications Department should be contacted for instructions on filing a claim for benefits. A representative will discuss the requirements, statements or other information needed to process the claim. All death benefits require submission of a certified death certificate along with a completed MCTWF claim form when filing the claim.

### **SEC. 13.8: CLAIM RECEIPT DEADLINE**

All claims for benefits must be received within fifteen months after the date the eligible expense is incurred (i.e., date the services were rendered) except that claims for death benefits, accidental death and dismemberment benefits, weekly accident and sickness benefits and total and permanent disability benefits must be received within fifteen months after the death, dismemberment or Disability occurs. If MCTWF requests additional information from you or your provider with regard to your claim, MCTWF must receive the response within 45 Days from the date of the request to respond.

## PART 14: IF YOUR CLAIM FOR BENEFITS IS DENIED - APPEAL PROCEDURE

MCTWF's Board of Trustees has full and absolute discretion, authority and power to interpret the terms of the MCTWF's Plan of benefits, determine all questions of coverage and eligibility and adjudicate benefit claims.

If your benefit claim is denied in whole or in part, you have the right to appeal. If you wish to appeal a benefit denial, you must submit the appeal in writing within 180 Days after you receive a denial of benefits. Appeals should be sent to the Appeals Department at the address below.

Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216-1269

You may submit with your appeal written comments, documents, or other information in support of your appeal. Inasmuch as the appeal will be decided by the Trustees, the appeal therefore will be decided by a person different from the person who made the initial claim decision and who is not a subordinate of the person who made the initial claim decision. No deference will be accorded to the initial benefit decision.

If a health care professional is consulted in connection with your appeal, MCTWF will consult with a health care professional different from the person who was consulted in the initial claim decision and who is not a subordinate of the person who was consulted in the initial claim decision. Upon request, your Plan Administrator will identify any medical expert whose advice was obtained on behalf of MCTWF in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

**Claims for Disability Benefits and Post-Service Claims for Benefits:** You will be notified of the decision on appeal of denial of Disability benefits and of post-service claims for healthcare benefits within a reasonable period of time, but no later than five Days after the monthly Trustee meeting at which your appeal is decided. If MCTWF receives your appeal less than 30 Days before the next Trustee meeting, your appeal will be decided at the second Trustee meeting following the date MCTWF receives your appeal. If MCTWF receives your appeal 30 or more Days before the next Trustee meeting, your appeal will be decided at the next Trustee meeting.

If special circumstances require additional time to process your appeal, you will be notified in writing of the reason for the extension and the date the claim will be decided, which will be no later than the third Trustee meeting following the date MCTWF receives your appeal.

**Concurrent Care and Pre-Authorization Claims for Benefits:** An appeal of an initial decision to reduce or terminate concurrent care (i.e., an ongoing course of treatment) that has not yet been provided will be decided as an appeal of a pre-authorization claim. You will be notified of the decision on appeal of denial of a pre-authorization claim within a reasonable period of time, taking into account the medical circumstances, but no later than 30 Days from the date MCTWF receives the appeal.

**Urgent Claims for Benefits:** An urgent claim is any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. You may request an expedited appeal of an urgent claim.

The request may be made orally, and MCTWF will communicate with you by telephone, facsimile, or similarly rapid communication method.

You will be notified of the decision on appeal of an urgent claim as soon as possible, taking into account the medical urgency, but not later than 72 hours after MCTWF receives the appeal.

**Notice of Appeal Decisions:** You will receive notice of the decision on your appeal. If your appeal is denied, the notice of adverse benefit decision will -

- state specific reason(s) for the adverse determination;
- refer to specific MCTWF Plan provision(s) on which the benefit determination is based;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request), if the denial is based on a Medical Necessity or Experimental treatment or similar limit; and
- include a statement regarding your right to commence a legal action under section 502(a) of ERISA.

**Legal Actions:** You may not bring a lawsuit to recover benefits under any MCTWF Plan unless you have exhausted your appeal rights under MCTWF. No action may be brought at all unless it is commenced within two Years after a final decision on your appeal. The two year statute of limitations applies in any forum where you may initiate an action to recover benefits.

MCTWF *Participant Benefit Claim Appeal* forms are available at no charge upon request from MCTWF's office or may be printed from MCTWF's website. The use of this form is requested but not required. It contains the necessary elements for our consideration of your appeal. It is also helpful in distinguishing between an appeal, a general inquiry and a request to consider additional information.

## PART 15: RIGHT TO RECOVERY

If MCTWF pays more than your MCTWF Plan provides, MCTWF has the right to recover the overpayment from one or more of the following:

- any person to whom payments were made;
- any persons for whom payments were made; and
- any insurance company or organization to whom payments were made.

You are required to provide MCTWF with any instructions and papers that may be necessary to recover overpayments. MCTWF also has the right to recover overpayments by deducting the overpayment amount from your future benefits.

If in the process of recovering an overpayment you are issued a final demand letter, you will have 30 Days to repay the full amount owed, otherwise coverage will be immediately suspended until such time as it is fully repaid. Eligibility to participate in any MCTWF self-contributory program, including the Retiree Medical Program or Retiree Death Benefit Program, will be immediately suspended. Once the overpayment is fully repaid, coverage will be retroactively reinstated.

## PART 16: ASSIGNMENT, SUBROGATION AND REIMBURSEMENT

When MCTWF pays any benefits for you, it immediately gains all rights of recovery against any person or entity that caused or contributed to the loss Covered by it. This is called subrogation. Where reasonable cause exists to believe there may be another source from which to recover for the same loss, payment of benefits is conditioned upon the execution by you of MCTWF's *Assignment, Subrogation and Reimbursement Agreement*. You may be eligible to receive benefits under an *Assignment, Subrogation and Reimbursement Agreement* if your workers' compensation claim is denied and you are appealing the ruling. All requests are reviewed on an individual basis. However, if your Dependent suffers a work related injury or Illness and she has other insurance which is primary to your MCTWF Plan, no *Assignment, Subrogation and Reimbursement Agreement* will be offered.

Furthermore, failure to comply with any provisions contained in such Agreement or in the SPD Booklet shall relieve MCTWF from any further benefit obligations related to the injury or Illness, and any benefits paid on behalf of you will result in an overpayment of benefits.

In addition, if you receive any payment from any source as a result of an injury or Illness, MCTWF has the right to reimbursement from you for all amounts it has paid and will pay as a result of that injury or Illness. MCTWF will be entitled to reimbursement up to the amount you receive, including heirs, executors, administrators, assigns, personal representatives, attorneys, or anyone else acting by, through or on your behalf, in any way related to the injury or Illness, whether or not such payments are designated as reimbursement for medical expenses. MCTWF has a lien on all such amounts, which shall be deemed assets of MCTWF.

If you fail to reimburse MCTWF, it has the right to deduct the amount of benefits paid from any future benefits payable to, or on behalf of you.

You and those acting on your behalf, including attorneys -

- may do nothing to prejudice MCTWF's assignment, subrogation and reimbursement rights;
- must provide MCTWF with information when requested;
- must cooperate with MCTWF in the enforcement of its assignment, subrogation and reimbursement rights; and
- must notify MCTWF immediately upon notification to any other party (or the party's attorney) of an intent to pursue damages.

Assignment, subrogation and reimbursement rights are a first priority claim against all potentially liable parties, and are not limited by any right you have to be made whole. MCTWF is to be paid before any other payments for you, whether such amounts are recoverable from, or paid by, any source to you, or any other individual, institution or trust.

Such first priority claim shall apply regardless of how and by whom such payments may be characterized, i.e., past medical expenses, future medical expenses, pain and suffering, loss of earnings, legal fees or expenses, or any other form of economic or non-economic damages whatsoever, and to the extent necessary to satisfy MCTWF's rights, any recovery will be deemed as compensation for medical expenses.

MCTWF is entitled to assignment, subrogation and reimbursement even if such amounts constitute only a partial recovery and are insufficient to compensate you for all damages sustained. MCTWF is not required to participate in any damage claim or pay attorney's fees to any attorney you hire to pursue the damage claim. This assignment, subrogation and reimbursement provision applies whether or not a third party admits liability for payment.

You may receive payment for medical services before benefits are paid under MCTWF. In that case, the benefit payable by MCTWF will be limited to the amount of benefits in excess of the amount already paid, if any. Such amounts include all direct or indirect payments to, or on behalf of, you for injury or illness from any source by settlement, judgment or any other means.

## PART 17: COORDINATION OF BENEFITS

An individual who is entitled to receive benefits under an MCTWF Plan may also be eligible for similar benefits under another group health plan.

If you have coverage under another group health plan, benefits under your MCTWF Plan will be coordinated with benefits under the other Plan.

If the MCTWF Plan is the Secondary Plan it will subtract the Primary Plan's payment from MCTWF's Allowed Amount (resulting in a "net amount allowed") and, subject to MCTWF Plan Deductible, Copayment and Coinsurance amounts (which are reduced up to the amount of the Primary Plan's payment), will pay the balance of applicable charges up to the net Allowed Amount.

A group health plan that does not have a coordination of benefits provision is always the Primary Plan. If all group health plans have a coordination of benefits provision, the Primary Plan is determined according to the following rules:

- The Plan covering the patient as an Employee rather than as a Dependent will be the Primary Plan (for example, if your Spouse needs a medical procedure and is covered by a health Plan provided by her Employer, her Employer's Plan is the Primary Plan).
- For Dependent children -
  - The Plan of the parent whose birth date falls earlier in the calendar year is the Primary Plan when -
    - > the parents are married;
    - > the parents are living together (regardless of whether they ever have been married);
    - > a court decree states both parents are responsible for the Dependent child's health care expenses or health care coverage; or
    - > a court decree awards joint custody but does not specify which parent is responsible for the Dependent child's health care expenses or health care coverage.If both parents have the same birth date, the Plan that has covered the parent the longest is the Primary Plan.
  - If a court decree designates only one of the parents as responsible for the Dependent child's health care expenses or health care coverage, that parent's Plan is the Primary Plan. If that designated parent has no health care coverage but his Spouse does, that parent's Spouse's Plan is the Primary Plan.
  - If no court decree allocates responsibility for the child's health care expenses or health care coverage, the order of coverage of plans is as follows:
    - > first, the Plan covering the custodial parent;
    - > second, the Plan covering the custodial parent's Spouse;
    - > third, the Plan covering the non-custodial parent; and
    - > fourth, the Plan covering the non-custodial parent's Spouse.

### SEC. 17.1: COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

If the patient's Primary Plan is a Health Maintenance Organization (HMO), the patient is required to use the approved HMO providers and follow all other applicable HMO rules.

If the patient's Primary Plan reduces benefits because of non-compliance with its specific provisions, the amount of that reduction will not be Covered under your MCTWF Plan. For instance, a patient may fail to request prior authorization as required under the patient's Primary Plan. If the patient then pays a penalty in the form of an additional Deductible because of non-compliance, that penalty will not be paid by your MCTWF Plan.

## SEC. 17.2: COORDINATION WITH MEDICARE

Medicare provides insurance to people who -

- are age 65 and older (if your birthday is on the 1st day of any month, Medicare is effective the 1st day of the prior month and if it is on the 2nd day of the month or later, Medicare is effective on the 1st day of the current month);
- are totally disabled; or
- have End Stage Renal Disease (ESRD).

It is your responsibility to notify MCTWF when you become eligible for Medicare Part A coverage. MCTWF must receive a copy of your Medicare card or a letter from the Social Security Administration stating the effective date of Medicare coverage.

### In the case of Active MCTWF Plan participation -

If you are enrolled in Medicare and are age 65 or more, or are enrolled in Medicare based on Disability, your Active MCTWF Plan is the Primary Plan for coordination of benefit purposes while you are actively employed.

If you are covered by Medicare due to ESRD, your Active MCTWF Plan is the Primary Plan for up to 30 months from the Medicare eligibility date. After the 30 month period, Medicare is primary for coordination of benefit purposes. Your Active MCTWF Plan benefits will be limited to those in excess of Medicare Part A and Medicare Part B benefits, up to your Active MCTWF Plan limits, regardless of whether the beneficiary has enrolled in Medicare Part B.

### In the case of COBRA continuation coverage Plan participation -

If you are enrolled in Medicare and are age 65 or more, or are enrolled in Medicare based on Disability, and elect COBRA continuation coverage, Medicare is the Primary Plan for coordination of benefit purposes. Your continuation coverage Plan benefits will be limited to those in excess of Medicare Part A and Medicare Part B benefits, up to your continuation coverage Plan limits, regardless of whether enrolled in Medicare Part B.

If you are covered by Medicare due to ESRD and elect COBRA continuation coverage, COBRA continuation coverage is primary for up to 30 months (less the period of time during which you received coverage for the disease under the Active MCTWF Plan) from the Medicare eligibility date. After the 30 month period, Medicare is the Primary Plan for coordination of benefit purposes. Your continuation coverage Plan benefits will be limited to those in excess of Medicare Part A and Medicare Part B benefits, up to your continuation coverage Plan limits, regardless of whether you have enrolled in Medicare Part B.

For more information about Medicare benefits, contact your local Social Security Administration office, visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE.

## SEC. 17.3: RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To the extent permitted by law, MCTWF reserves the right to release or obtain any information about you to or from any insurance company, Hospital, Physician or other organization or individual to determine how benefits will be paid. In addition, if you are claiming benefits under your MCTWF Plan, you will be required to provide any necessary information to MCTWF.

## PART 18: NON-ALIENATION OF BENEFITS

Your benefits under your MCTWF Plan may not be assigned by MCTWF or seized to pay your debts unless -

- you have voluntarily assigned your benefit to pay a health care provider for services Covered under your MCTWF Plan; or
- you are subject to a domestic relations order or child support order that meets the requirements of a Qualified Domestic Relations Order (QDRO) or a Qualified Medical Child Support Order (QMCSO) under the Employee Retirement Income Security Act of 1974 (ERISA).

This rule does not affect MCTWF's right to recover overpayments it made to you or on your behalf.

Health Insurance Portability and Accountability Act (HIPAA) - HIPAA is a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also gives the Federal Government the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and Employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

MCTWF's HIPAA Privacy Rules, which are pursuant to Regulations by the U.S. Department of Health and Human Services and became effective April 14, 2003, are designed to provide you with guaranteed protection and security of your health care information – information that your Doctor, Hospital, pharmacist and other health care provider might have regarding your medical condition and treatments you receive from them. The Privacy Rules (as outlined in the Notice of Privacy Practices) also affect how MCTWF operates on your behalf as well.

### SEC. 19.1: NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### 19.1(a) USE AND DISCLOSURE OF HEALTH INFORMATION

MCTWF may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for purposes of making or obtaining payment for your care and conducting health care operations. MCTWF has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used or disclosed:

**To Make or Obtain Payment.** MCTWF may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, MCTWF may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**To Conduct Health Care Operations.** MCTWF may use or disclose health information for its own operations to facilitate the administration of MCTWF and as necessary to provide coverage and services to all of MCTWF's Participants and beneficiaries. Health care operations include such activities as -

- quality assessment and improvement activities;
- activities designed to improve health or reduce health care costs;
- clinical guideline and protocol development, case management and care coordination;
- contacting health care providers, Participants and beneficiaries with information about treatment alternatives and other related functions;
- health care professional competence or qualifications review and performance evaluation;
- accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;

- review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- business planning and development including cost management and planning related analysis and formulary development;
- business management and general administrative activities of MCTWF, including member services and resolution of internal grievances; and
- certain marketing activities.

For example, MCTWF may use your health information to conduct case management, quality improvement, disease management, utilization review, and provider credentialing activities or engage in member service and grievance resolution activities.

**For Treatment Alternatives.** MCTWF may use or disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health Related Benefits and Services.** MCTWF may use or disclose your health information to provide to you information on health related benefits and services that may be of interest to you.

**For Disclosure to Plan Sponsor.** MCTWF may disclose your health information to the Plan sponsor, the Trustees of the Michigan Conference of Teamsters Welfare Fund, for plan administration functions.

**Where Required or Permitted by Law.** MCTWF also may use or disclose your health information where required or permitted by law. Federal law, under HIPAA generally permits health plans to use or disclose health information for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; for certain government functions, such as related to military service or national security; or to comply with workers' compensation laws.

### **19.1(b) AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than as stated above, MCTWF will not disclose your health information other than with your written authorization. If you authorize MCTWF to use or disclose your health information, you may revoke that authorization in writing at any time.

### **19.1(c) YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that MCTWF maintains:

**Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on MCTWF's disclosure of your health information to someone involved in the payment of your care. However, in most cases, MCTWF is not required to agree to your request. If you have paid for your own coverage out-of-pocket in full, MCTWF may have to comply with your request, depending on your situation. If you wish to make a request for restrictions, or for further information, please contact MCTWF's Privacy Officer at (313) 964-2400.

**Right to Receive Confidential Communications.** You have the right to request that MCTWF communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that MCTWF only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing and mail to:

Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. MCTWF will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. If you request a copy of your health information, MCTWF may charge a reasonable fee for copying, assembly and postage, if applicable, associated with your request.

**Right to Amend Your Health Information.** You have the right to request an amendment to your health information records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by MCTWF. A request for an amendment of records must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. MCTWF may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request also may be denied if your health information records were not created by MCTWF, if the health information you are requesting to amend is not part of MCTWF's records, if the health information you wish to amend includes information you are not permitted to change, or if MCTWF determines the records containing your health information are accurate and complete.

**Right to an Accounting.** You have the right to obtain a list of disclosures of your health information made by MCTWF for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. The right to an accounting does not extend beyond six Years back from the date of your request. MCTWF will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost based fee. MCTWF will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice.** You have a right to obtain and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy, please contact the Privacy Officer at (313) 964-2400. You also may obtain a copy of the current version of the Notice at MCTWF's website.

### **19.1(d) DUTIES OF MCTWF**

MCTWF is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. MCTWF is required to abide by the terms of this Notice, which may be amended from time to time. MCTWF reserves the right to change the terms of this Notice by providing you with a copy of a revised Notice within 60 Days of a material change and by making the new Notice provisions effective for all health information that it maintains.

If MCTWF changes its policies and procedures, MCTWF will revise the Notice and will provide a copy of the revised Notice to you within 60 Days of any material change. You have the right to express complaints to MCTWF and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to MCTWF should be made in writing and mailed to:

Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. MCTWF encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

### **19.1(e) TO CONTACT MCTWF WITH QUESTIONS**

Submit your written questions regarding your privacy rights to: Customer Communications Department, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216, or direct your calls to MCTWF's Customer Communications Department.

## PART 20: YOUR RIGHTS UNDER ERISA

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to -

### SEC. 20.1: RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to -

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing your MCTWF Plan. These include insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual report (Form 5500 Series) filed by your MCTWF Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of your MCTWF Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest Annual report (Form 5500 Series) and updated SPD Booklet. The administrator may make a reasonable charge for the copies.
- Receive a summary of your Plan's Annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

### SEC. 20.2: CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to -

- Continue health care coverage for yourself if there is a loss of coverage under your MCTWF Plan as a result of a qualifying event. You may have to pay for such coverage. Review this SPD Booklet and the documents governing the MCTWF Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another Plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when -
  - you lose coverage under your MCTWF Plan;
  - you become entitled to elect COBRA continuation coverage; or
  - your COBRA continuation coverage ceases.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### SEC. 20.3: PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for you, ERISA imposes duties upon the people who are responsible for the operation of your MCTWF Plan. The people who operate your MCTWF Plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other MCTWF Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or otherwise exercising your rights under ERISA.

## **SEC. 20.4: ENFORCE YOUR RIGHTS**

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of your MCTWF Plan documents or the latest Annual report from your MCTWF Plan and do not receive them within 30 Days, you may file suit in a federal court. In such a case, the court may require your Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of your Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with your MCTWF Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that your MCTWF Plan fiduciaries misuse your MCTWF Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **SEC. 20.5: ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your MCTWF Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or -

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For single copies of publications, contact the EBSA at (866) 444-3272 or contact the EBSA field office nearest you.

You may also find answers to your MCTWF Plan questions at the website of the EBSA at <http://www.dol.gov/ebsa/>. A list of EBSA field offices is located at [http://www.dol.gov/ebsa/AboutEBSA/org\\_chart.html#section13](http://www.dol.gov/ebsa/AboutEBSA/org_chart.html#section13)

## **PART 21: PLAN ADMINISTRATION INFORMATION**

The following material provides information about how your MCTWF Plan is administered:

### **SEC. 21.1: NAME AND ADDRESS OF PLAN**

Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216  
(313) 964-2400  
(800) 572-7687

### **SEC. 21.2: PLAN SPONSOR**

Trustees of the Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216  
(313) 964-2400  
(800) 572-7687

### **SEC. 21.3: EMPLOYER IDENTIFICATION NUMBER (EIN)**

38-1328578

### **SEC. 21.4: PLAN NUMBER**

501

### **SEC. 21.5: TYPE OF WELFARE PLAN**

Your MCTWF Plan provides medical, prescription drug, dental, vision, death, accidental death and dismemberment, weekly accident and sickness and total and permanent disability benefits. Your Plan is self-insured by the Michigan Conference of Teamsters Welfare Fund.

### **SEC. 21.6: TYPE OF PLAN ADMINISTRATION**

Your Plan is administered by the Trustees of the Michigan Conference of Teamsters Welfare Fund.

### **SEC. 21.7: PLAN ADMINISTRATOR**

Trustees of the Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216  
(313) 964-2400  
(800) 572-7687

## **SEC. 21.8: PLAN TRUSTEES**

The following individuals are Trustees of your MCTWF Plan:

### **Union Trustees**

William A. Bernard  
Robert F. Rayes  
H.R. Hillard  
Dennis Hands

### **Employer Trustees**

Robert J. Lawlor  
Howard McDougall  
Raymond J. Buratto  
Earl D. Ishbia

The mailing address for each Trustee is: 2700 Trumbull Avenue  
Detroit, Michigan 48216

## **SEC. 21.9: COLLECTIVE BARGAINING AGREEMENTS**

Your MCTWF Plan is maintained according to a number of Collective Bargaining Agreements. You may obtain a copy of your Collective Bargaining Agreement upon request to the Plan Administrator.

## **SEC. 21.10: SOURCES OF CONTRIBUTIONS TO YOUR PLAN**

Contributions are made by Employers according to the terms of applicable Collective Bargaining Agreements or Participation Agreements. In certain circumstances, you are permitted to make Contributions to your MCTWF Plan.

## **SEC. 21.11: FUNDING**

Your MCTWF Plan is funded by Contributions to the MCTWF Trust and earnings from Trust investments.

## **SEC. 21.12: PLAN YEAR**

Your Plan Year begins on April 1st and continues through March 31st.

## **SEC. 21.13: AGENT FOR SERVICE OF LEGAL PROCESS**

For disputes arising under your Plan, service of legal process may be made on the Executive Director, Plan Administrator or any individual Trustee at 2700 Trumbull Avenue, Detroit, Michigan 48216.

## **SEC. 21.14: ADMINISTRATIVE SERVICES**

Blue Cross Blue Shield of Michigan (BCBSM), Delta Dental of Michigan, CVS Caremark and Value Options provide certain administrative services under your Plan. Their addresses are:

Blue Cross Blue Shield of Michigan  
27000 W. Eleven Mile Road  
Southfield, Michigan 48034

Delta Dental of Michigan  
4100 Okemos Rd.  
Okemos, Michigan 48864

ValueOptions  
48561 Alpha Drive, Suite 150  
Wixom, Michigan 48393-3442

CVS Caremark  
2211 Sanders Road  
Northbrook, Illinois 60062

BCBSM, Delta Dental of Michigan, CVS Caremark and ValueOptions are not authorized to make final benefit claim decisions under MCTWF Plan. Questions concerning claims or benefits under your MCTWF Plan should be sent to MCTWF.

### **21.14(a) EMPLOYMENT RIGHTS NOT GUARANTEED**

Your eligibility for, or participation in your MCTWF Plan does not guarantee your rights to benefits other than those specified in this SPD Booklet, nor does it guarantee your employment rights with a Contributing Employer.

### **21.14(b) PLAN AMENDMENT OR TERMINATION**

The provisions of your MCTWF Plan may be amended from time to time or terminated, by a majority vote of the Trustees. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits.

Amendments to or termination of your MCTWF Plan can be made at any time and for any reason. In the event of elimination, reduction or modification of benefits, you or your beneficiary may be required to pay for benefits that were formerly Covered by your MCTWF Plan. In the event of increases or other modification of benefits, you or your beneficiary may no longer be required to pay providers for benefits that were not formerly Covered by your MCTWF Plan.

### **21.14(c) MCTWF TERMINATION**

MCTWF may be terminated at any time and for any reason. In such event, the Trustees will take necessary steps to wind down the Trust. In conformity with the provisions of the Trust Agreement, the Trustees will apply the Plan Trust assets to pay or to provide for the payment of all obligations of MCTWF. Any remaining surplus will, in accordance with the terms of the Trust Agreement, be used in such manner as the Trustees believe will best effectuate the purpose of MCTWF, subject to the requirement that no part of the assets of the Trust may be diverted to any purpose other than the exclusive benefit of Participants and beneficiaries and payment of the administrative expenses of MCTWF. Upon termination, no part of the assets of MCTWF will revert or accrue, directly or indirectly, to the benefit of an Employer or the Union.

The Trustees have the full and absolute discretion, authority and power to interpret, control and implement the terms and provisions of all documents and instruments governing MCTWF including, but not limited to, the terms of the benefits plans, rules, regulations and policies adopted by the Trustees, or to alter, amend or terminate the Plan.

The Trustees also have the full and absolute discretion, authority and power to determine -

- all questions regarding MCTWF coverage and eligibility;
- methods of providing benefits;
- all matters concerning the operation of MCTWF; and
- all claims for benefits.

Benefits under your Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

## PART 22: IMPORTANT DEFINITIONS

The following are definitions of specific words and terms used in this SPD Booklet:

**Accident** means an unexpected or unintentional occurrence.

**Accidental Injury** means a bodily injury that is the direct result of an Accident and is not related to any cause other than the Accident.

**Active** refers to Employees of Contributing Employers or those benefits or Plans of benefits available to Employees of Contributing Employers (and their Dependents).

**Allowed Amount** means the portion of the Amount Billed which has been established either by contract with the provider, or in the case of an Out-of-Network provider, as your MCTWF Plan's Maximum Allowable Benefit, which is subject to Plan Deductible, Copayment and Coinsurance amounts, as well as Out-of-Pocket Maximums.

**Amount Billed** means the Amount Billed by the health care professional who rendered the service.

**Amount Not Covered** means the difference between the Amount Billed and the MCTWF Plan's Allowed Amount.

**Amount Paid** means the Amount Paid by your MCTWF Plan to you or your provider, after the application of any Deductible, Copayment and Coinsurance amounts, and coordination of benefits (when applicable).

**Annual** means one calendar year beginning January 1st and ending December 31st.

**Brand Name Drug** means a prescription drug that has a trade name and is protected by patent.

**Coinsurance** means the percentage of the Allowed Amounts you must pay regardless of any individual or family Deductible amount for which you are responsible, and is based on whether services are provided by a Network or Out-of-Network provider.

**Collective Bargaining Agreement** means the negotiated labor agreement between the International Brotherhood of Teamsters, or any of its constituent Local Unions, and your Employer.

**Copayment** means the flat dollar amount you are responsible for paying when you receive medical services or obtain prescription drugs and may depend on whether services are provided by a Network or Out-of-Network provider.

**Contracted Charges** means the maximum agreed upon fees payable to Network providers.

**Contributions** mean payments made to MCTWF by an Employee, Contributing Employer, Retiree or parent of a Dependent child pursuant to a QMSCO.

**Covered** means eligible to receive MCTWF Plan benefits.

**Custodial Care** means care that, either because of its simplicity or the stability of the patient's condition, can be competently delivered by anyone, trained or not, in the various specialties of medical service. The skills required, in general, are those that do not require special decision making processes (of a medical nature), special medical judgment in terms of a changing medical condition, or a unique experience only available to those specially trained in medical services.

**Days** means calendar Days unless stated as business days.

**Deductible** means the amount of Covered medical expenses you must pay Annually before your MCTWF Plan begins paying on a calendar year basis (January 1st through December 31st). The deductible may apply to the individual, or the family, or both and may depend on whether services are provided by a Network or Out-of-Network provider.

**Dependent** means a person who is -

- the Participant's Spouse;
- the Participant's unmarried natural or step child, or child who has been placed with him for adoption, or whom he has adopted, through the end of the child's 19th birthday month;
- the Participant's unmarried natural or step child, or child who has been placed with him for adoption, or whom he has adopted, age 19 through the end of the child's 24th birthday month and who is a full-time student;
- the Participant's unmarried natural or step child, or child who has been placed with him for adoption, or whom he has adopted, age 19 through the end of the child's 24th birthday month who was Covered as a full-time student (as reflected by an MCTWF *Full-Time Student Eligibility Verification Form*) on the date the child graduated from high school and who demonstrates (through a letter from an accredited academic institution or an accredited vocational school) the child's acceptance for enrollment for the subsequent school term as a full-time student; and
- the Participant's unmarried natural or step child, or child who has been placed with him for adoption, or whom he has adopted, regardless of age, who has been determined by a licensed Physician, psychologist or psychiatrist to be permanently and totally disabled by a Disability. The Trustees have the discretion and reserve the right to challenge the determination made by the licensed Physician.

**Disability** means the inability to perform the regular duties of employment because of a non-occupational or non-auto-related Accident or Sickness, or due to pregnancy.

**Doctor or Physician** means one who is licensed to practice as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Chiropractic Medicine (D.C.).

**Durable Medical Equipment (DME)** is equipment that -

- can withstand repeated use;
- is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or Illness; and
- is not disposable or non-durable.

**Employee** means a person for whom an Employer is obligated to make Contributions to MCTWF under a Collective Bargaining Agreement or an MCTWF Participation Agreement.

**Employer, Contributing Employer or Participating Employer** means any firm, association, partnership or corporation that is obligated to make Contributions to MCTWF pursuant to the terms of a Collective Bargaining Agreement and/or an MCTWF Participation Agreement.

**Experimental or Investigative** refers to care, treatments, services, procedures or supplies that are not yet recognized as accepted medical practice by the general medical community in the state where the services are provided, or devices or drugs that have not yet received required governmental approval. This includes, but is not limited to, trial procedures or protocols performed on a minimal number of patients to establish data for a rate of cure or improvement in the quality of life, and care, treatment, services and supplies not considered reasonable and customary by any government agency or subdivision, including as provided in the CMS Medicare Coverage Issues Manual.

**Extended Retiree Spouse** means the Spouse of a former Retiree Medical Program Participant who has exhausted her right to obtain Program coverage at the Retiree self-Contribution rate and who is now participating in the Program at the cost-based rate.

**Family and Medical Leaves** means absence from work pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA).

**Generic Drug** means a prescription drug which is produced and distributed without patent protection. Generic Drugs must contain the same active ingredients as their Brand Name Drug counterparts. Generic Drugs are considered by the Food and Drug Administration as identical in dose, strength, route of administration, safety, efficacy and intended use as their Brand Name Drug counterparts.

**Hospital** means an institution that -

- is accredited by The Joint Commission;
- is eligible to participate in and to receive payments in accordance with the provisions of Medicare; or
- meets all of the following requirements:
  - provides, on an inpatient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of Doctors licensed to practice medicine;
  - provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses; and
  - is operated continuously with organized facilities for operative surgery on the premises.

**Local Union** means those Local Unions affiliated with the International Brotherhood of Teamsters.

**Maximum Allowable Benefit (MAB)** means your MCTWF Plan's allowable portion of the Amount Billed by a provider that does not participate in the BCBS, MultiPlan, ValueOptions or Delta Dental of Michigan Networks, subject to Deductible, Copayment and Coinsurance amounts.

**MCTWF** means the Michigan Conference of Teamsters Welfare Fund.

**MCTWF Plan** means a group health plan administered according to rules described in this Booklet and in any other written documents that the Trustees designate under the terms of the Trust Agreement.

**Medical Attention** means under the regular care of a qualified healthcare provider.

**Medically Necessary** means those services, treatments or supplies provided to you by a Hospital or healthcare professional, which services are required, in the judgment of the Trustees, to identify or treat a condition, disease, injury or Illness and -

- are consistent with the symptoms, diagnosis or treatment of the condition, disease, injury or Illness;
- are appropriate according to acceptable standards of good medical practice;
- are not solely for the convenience of you, the Hospital or the healthcare professional;
- are the most appropriate that can be safely provided to you under the circumstances; and
- are not Experimental or Investigative in nature.

**Medicare** means the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965 (Public Law 89-87), as this Program is currently constituted and as it later may be amended.

**Months** mean units of time, measured from the date of a given event and ending on a date, that number of months later, one calendar day prior.

**Network** means a group of Hospitals and/or healthcare professionals who are bound by contract to certain standards of conduct and fee schedules as payment in full (excluding any applicable Deductible, Copayment and Coinsurance amounts) for healthcare services.

**Out-of-Network** means those Hospitals and/or healthcare professionals that are not in the Network and therefore may charge, without limitation, for their services.

**Out-of-Pocket Maximum** means the amount of money that you will have to spend for Coinsurance charges during each calendar year and is based on whether your medical services are provided by a Network or Out-of-Network provider.

**Participant** means Employee or Retiree.

**Participation Agreement** means a written agreement signed by an Employer pursuant to which the Employer contributes to MCTWF.

**Primary Plan** means the Plan that pays benefits first when more than one group health plan provides coverage to you.

**Prohibited Employment** means (a) employment, by an Employer, in any position, or (b) 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 (c) 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 MCTWF.

**Retirement Date** means the date an Employee ceases to be Covered by MCTWF as an Active Employee as a result of retirement, after application of all remaining benefit bank weeks. In certain circumstances, the purchase of COBRA continuation coverage may extend the Employee's Retirement Date until the cessation of such coverage (see page 20, Sec. 2.3(a), COBRA Continuation Coverage Contributions).

**Retiree** means a former Employee of an Employer that made Contributions to MCTWF under the terms of a Collective Bargaining Agreement or under an MCTWF Participation Agreement, who meets the requirements for enrollment in MCTWF's Retiree Medical Program.

**Schedule of Benefits** means the document that describes the specific benefits that comprise an MCTWF Plan and how those benefits are administered. The Schedule of Benefits is one component of the Summary Plan Description.

**Seasonal Work** means work that is performed only during certain seasons.

**Secondary Plan** means the Plan that pays benefits not Covered or not completely Covered by the Primary Plan when more than one group health plan provides coverage to you.

**Sickness or Illness** means any disorder of the body or mind (but not an injury) and pregnancy (including abortion, miscarriage, or childbirth).

**Skilled Nursing Facility** means an institution, or distinct part of an institution, that -

- has in effect a transfer agreement with one or more Hospitals;
- is primarily engaged in providing inpatient skilled nursing care;
- is duly licensed;
- has one or more Physicians and one or more registered professional nurses responsible for patient care;
- requires that patients be under the care of a Physician;
- maintains clinical records for all patients;
- provides 24-hour-a-day nursing services;
- provides procedures to dispense drugs and medications;
- has a utilization review plan in effect;
- is eligible to participate in Medicare; and
- is not an institution that primarily covers the care and treatment of mental diseases or tuberculosis.

**Spouse** means an individual recognized as a Spouse of the Participant under the law of the State of Michigan.

**Summary Plan Description (SPD)** means this Booklet, the Plan's Schedule of Benefits, and any material modifications thereof as published in MCTWF's newsletter, the *Messenger*.

**Total and Permanent Disability (TPD) or Totally and Permanently Disabled** means a determination by the Trustees that you have a physical or mental condition 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.

**Trust Agreement** means the documents, including all amendments, establishing MCTWF and its rules of operation.

**Trustees** means the individuals appointed and designated according to the terms of the Trust Agreement to administer your MCTWF Plan.

**Union** means the International Brotherhood of Teamsters.

**Years** means a period of 365 Days.

**You** means the Participant and his Dependents.