



SUMMARY PLAN DESCRIPTION



Michigan Conference
of Teamsters Welfare Fund
Summary Plan Description

DENTAL AND OPTICAL
July 2001



IMPORTANT – PLEASE NOTE

Some of the benefits described in this Summary Plan Description booklet may not be offered under your plan of benefits. You should read this booklet along with the Schedule of Benefits. The Schedule of Benefits describes the details of the benefits offered to you under your plan and it is a part of this Summary Plan Description.

If you have any questions about the benefits you are entitled to receive, please contact the Welfare Fund's Member Services Department at (313) 964-2400 or (800) 572-7687 (from the Metro-Detroit area), (800) 824-3158 (from the Upstate Michigan area) or (800) 334-9738 (from Outside of Michigan).

BOARD OF TRUSTEES

Labor Trustees

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

Management Trustees

Robert J. Lawlor
Howard McDougall
Raymond J. Buratto

IMPORTANT PHONE NUMBERS

To verify your eligibility for benefits, to request prior authorization of durable medical equipment and orthotics or to determine the status of your claim, you may call:

(313) 964-2400	Michigan Conference of Teamsters Welfare Fund Office
(800) 572-7687	Toll free Metro-Detroit
(800) 824-3158	Toll free Upstate Michigan
(800) 334-9738	Toll free Outside of Michigan

The health and welfare benefits described in this booklet apply to many different plans offered by the Michigan Conference of Teamsters Welfare Fund. You should refer to your Schedule of Benefits that is included as a part of this booklet to determine whether you are covered for particular benefits and the level of that coverage. Some of the benefits described in this booklet may not apply to your Plan. If you have any questions about the benefits you are entitled to receive, please contact the Welfare Fund's Member Services Department.

TABLE OF CONTENTS

INTRODUCTION	1
ELIGIBILITY	2
ENROLLING IN THE PLAN	4
LOSS OF BENEFITS	5
COBRA: CONTINUING YOUR BENEFITS	10
DENTAL BENEFITS	13
OPTICAL BENEFITS	22
APPEAL PROCEDURE IF YOUR CLAIM FOR BENEFITS IS DENIED	23
SUBROGATION AND REIMBURSEMENT	25
COORDINATION OF BENEFITS	26
NON-ALIENATION OF BENEFITS	27
YOUR RIGHTS UNDER ERISA	28
PLAN ADMINISTRATIVE INFORMATION	30
IMPORTANT DEFINITIONS	33

INTRODUCTION

This booklet is a Summary Plan Description (SPD) of your Plan in effect as of July 1, 2001. The Dental and Optical Plan is a group health plan that provides dental and optical benefits.

This booklet will help you understand your benefits and use them well. You should review it and also show it to family members covered by the Plan. 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
- your responsibilities to provide necessary information to the Plan.

A separate Schedule of Benefits is included as part of this Summary Plan Description. Please refer to the Schedule of Benefits for the specific amount of your benefits and benefit limitations.

When the Plan is amended from time to time, the Welfare Fund Office will send you a notice explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Although this SPD provides accurate and essential information about the Plan, you should understand that it is not a complete description. If there is a conflict or discrepancy between the information in this booklet and the terms of the Master Plan Document, the facts or position stated in the Master Plan Document will govern. The Master Plan Document is available for your review at 2700 Trumbull Avenue, Detroit, Michigan between 9 a.m. and 4 p.m. on regularly scheduled business days.

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 the Welfare Fund is terminated, assets of the Welfare Fund after paying claims, if any, may be used to pay Welfare Fund expenses or may be contributed to a new welfare benefit plan established through collective bargaining.

If there is anything about these benefits that you don't understand, contact the Welfare Fund Office. We will be happy to assist you.

ELIGIBILITY

If you are a full time employee on the date your employer starts participating in the Welfare Fund, you are eligible for coverage under this Plan on that date. Except in certain cases of reinstatement (see Reinstatement on page 9) your eligibility is subject to the following provisions.

WHEN YOUR COVERAGE BEGINS

You are covered by the Plan on the first Sunday of the week after your employer has made contributions to the Welfare Fund on your behalf for:

- eight consecutive weeks; or
- nine weeks within a thirteen week period,

provided that contributions are received for the ninth week. If no contributions are submitted for the ninth week, then coverage does not begin.

Example Your employer begins making contributions to the Welfare Fund on your behalf on Monday, May 2nd. Contributions are made for eight weeks in a row. You would be covered by the Plan beginning on Sunday, June 26th because that is the Sunday after the end of the eighth week, provided contributions are made for the ninth week.

Contributions Begin	Monday, May 2
End of Week 1	Saturday, May 7
End of Week 2	Saturday, May 14
End of Week 3	Saturday, May 21
End of Week 4	Saturday, May 28
End of Week 5	Saturday, June 4
End of Week 6	Saturday, June 11
End of Week 7	Saturday, June 18
End of Week 8	Saturday, June 25
Contribution received for Week 9:	
Coverage Begins	Sunday, June 26

There are other circumstances that may affect your participation in the Plan:

- If you are on layoff the day your benefits would normally become effective and you return to work within 26 weeks, your coverage will not begin until you return to active employment. If you are laid off for 26 weeks or more, see the section entitled Reinstatement on page 9.
- If you are covered by another Teamsters welfare fund and your employer becomes a contributing employer under this Plan, you will become a participant in this Plan on the date of transfer.

You may verify your eligibility by calling Member Services at (313) 964-2400, or toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan.

COVERING YOUR DEPENDENTS

Plan coverage is available for your “eligible dependents.” Your eligible dependents become covered by the Plan when your coverage begins, or if later, on the date they become your eligible dependents (for example, on the date of your marriage or child’s birth, etc.). Your eligible dependents include:

- your spouse;
- your unmarried child by birth, marriage or adoption, or child who has been placed with you for adoption, who is not yet 19 years old and who you claimed as a dependent on your most recent federal income tax return;
- your unmarried child by birth, marriage or adoption who is 19-23 years old, who you claimed as a dependent on your most recent federal income tax return and who is regularly attending an accredited school on a full-time basis, as demonstrated by a student data verification form submitted to the Welfare Fund Office for each school semester, quarter or other grading period that you want benefit coverage to continue. To meet this requirement for post-high school studies, the student must be enrolled full-time in a degree or certification program offered by an accredited academic institution or vocational school; and
- your unmarried dependent child by birth, marriage or adoption who you claimed on your most recent federal income tax return, regardless of age, who has been determined by a licensed physician, psychologist or psychiatrist to be permanently and totally disabled by a disability that began while he or she was covered under the Welfare Fund as an eligible dependent. The Trustees have the discretion and reserve the right to challenge the determination made by the licensed physician.

ENROLLING IN THE PLAN

When you become eligible for benefits, you will receive an enrollment card. You must complete the front and back of the card, sign the back and return it to the Welfare Fund Office.

You must complete this card in an accurate and timely manner. If the Welfare Fund receives a claim for you or one of your dependents, processing your claim and reimbursing your expenses may be delayed or your benefits may be suspended if you have not:

- completed the enrollment card;
- provided accurate information; and
- notified the Welfare Fund Office of changes in the information you provided.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

1. According to federal law, a Qualified Medical Child Support Order (QMCSO) is a child support order of a court that usually results 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.
2. If a court has issued an order with respect to health care coverage for any of your dependent children, the Welfare Fund will determine if the court order is a QMCSO as defined by federal law. The Welfare Fund's determination will be binding on you, the other parent, the child and anyone acting on the child's behalf.
3. The QMCSO may not require that this Plan provide any benefits that are not otherwise provided. However, if you are a participant in the Plan, the QMCSO may require the Plan to provide coverage for your dependent child and to accept contributions for their coverage from a parent who is not a Plan participant. The 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 enrollment card is received by the Plan. Coverage is subject to all terms and provisions of the Plan, including the limits on selection of provider and requirements for prior authorization of services, as permitted by applicable law.
4. If you are eligible, but not covered by the Plan at the time the QMCSO is received and the QMCSO orders you to provide coverage for your dependent child, the 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 the Plan, and will be subject to all terms and provisions of the Plan as permitted by applicable law.

5. 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.
6. The QMCSO may also require the 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 the Plan, and if the Plan Administrator determines that the QMCSO is valid, Plan benefits will be paid as required by that QMCSO.

FAMILY STATUS CHANGES

You must notify the Welfare Fund when you have a “change in family status.” Changes in family status include marriage, divorce, death, birth, adoption, change in your spouse's employment and adding or losing a dependent. If the Plan makes any payments in error because you did not report a family status change, you will be responsible for repaying those amounts to the Plan.

LOSS OF BENEFITS

You and your eligible dependents may lose benefit coverage under the Plan in the following circumstances:

- your employment with a contributing employer ends;
- your employer stops making contributions to the Welfare Fund on your behalf;
- you stop making self-contributions;
- your employer no longer participates in the Welfare Fund; or
- the Trustees of the Welfare Fund change, amend or terminate this Plan.

WHEN YOUR COVERAGE ENDS

In most cases, your coverage under this Plan ends at midnight on the Saturday of the last week your employer makes contributions to the Welfare Fund on your behalf.

Even if this happens, however, coverage will continue for you and your eligible dependents if you:

- have a balance in your Benefit Bank (see Using Your Benefit Bank on page 6);
- are receiving Weekly Accident & Sickness Benefits; or
- are eligible to purchase continued coverage (see COBRA: Continuing Your Benefits, on page 10) and you make the required payments on time.

BENEFIT BANKS

Using Your Benefit Bank

You should refer to your Schedule of Benefits to learn whether you are eligible for this benefit. If you have Benefit Bank coverage, this lets you and your dependents continue receiving benefits when your employer does not make contributions to the Welfare Fund on your behalf. The Benefit Bank helps you avoid interruptions in benefit coverage that could occur if you are:

- Sick.
- Laid off.
- On personal leave.
- On military leave.
- On sanctioned strike.
- Transferred to another employer whose employees are covered under this Plan.

If the Benefit Bank is available to you as indicated in your Schedule of Benefits, you will become eligible for the Benefit Bank on the date your Plan coverage begins.

If you were in the process of using your Benefit Bank weeks before the date on which your Benefit Bank weeks expire, you are allowed to deplete your prior Benefit Bank weeks. When you return to work after the Benefit Bank renewal date, you may receive the number of Benefit Bank weeks specified in your Schedule of Benefits during that three-year period. If, on the renewal date your employer is not making self-contributions on your behalf because you are not actively-at-work, your Benefit Bank weeks will renew upon your return to active employment.

Benefit Bank weeks may be used to continue coverage for you and your dependents when the Welfare Fund does not receive contributions on your behalf from your employer. You can also use any remaining Benefit Bank weeks when you retire.

You Are Not Eligible for the Benefit Bank, however:

- as the result of voluntary or involuntary termination of employment; or
- if your employer discontinues participation in the Welfare Fund; or
- your Schedule of Benefits does not provide Benefit Bank coverage; or
- if your employer began participation in the Welfare Fund before May 1, 1992 and your Collective Bargaining Agreement provides for immediate coverage under this Plan, instead of coverage beginning after eight consecutive weeks.

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 complete an approved course of evaluation/rehabilitation by the Welfare Fund's Behavioral Healthcare Program;
- documentation shows that you satisfactorily completed the Program and are capable of returning to work;
- you return to work with Employer contributions on your behalf; and
- you have Benefit Bank weeks available to post retroactively against the period, or a portion of the period of your evaluation and treatment.

When your Benefit Bank runs out, you can make contributions to continue medical benefit coverage. See the section entitled, COBRA: Continuing Your Benefits, on page 10.

WHEN YOUR EMPLOYMENT ENDS

This information will help you understand your benefit status when your employment with a contributing employer ends.

Termination

If you voluntarily end your employment or you are discharged, your coverage will end when your employer stops making contributions to the Welfare Fund on your behalf.

When your coverage ends you may be able to purchase continued coverage. For details about continued coverage, see COBRA: Continuing Your Benefits, on page 10.

Layoff

If you are laid off, your employer will stop making contributions to the Welfare Fund on your behalf. Your benefits will remain in effect for as long as you have weeks remaining in your Benefit Bank if your Plan provides Benefit Bank weeks. When your Benefit Bank runs out, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 10.

LEAVES OF ABSENCE

Family and Medical Leave

Under the Family and Medical Leave Act of 1993, you may qualify to take up to 12 weeks of unpaid leave:

- for your own serious illness; or
- to care for your newborn child or newly adopted child; or
- to care for your seriously ill spouse, parent or child.

If the Family and Medical Leave Act applies to you (small employers – those with fewer than 50 employees within a 75-miles radius – are exempt), 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 Act 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 federal law and continues to make the required contributions to the Welfare Fund 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 Family and Medical Leave Act.

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.
- After 30 days, you may be able to continue your medical coverage at your own expense for up to 18 months.

Contact the Welfare Fund Office with any questions regarding the continuation of medical coverage while on military leave.

Other Leaves

If you take any other leave of absence, your employer will stop making contributions to the Welfare Fund on your behalf. Your benefits will remain in effect for as long as you have weeks remaining in your Benefit Bank if your Plan provides Benefit Bank weeks. When your Benefit Bank runs out, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 10.

ILLNESS

If you are unable to work because you are ill, your employer may stop making contributions to the Welfare Fund on your behalf. Your benefits will remain in effect for as long as you have weeks remaining in your Benefit Bank if your Plan provides Benefit Bank weeks. When your Benefit Bank runs out, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 10.

TEMPORARY WORK STOPPAGE

If you are unable to work because of a Temporary Work Stoppage (TWS), your employer will stop making contributions to the Welfare Fund on your behalf. The Welfare Fund will continue to provide benefits whether or not contributions are made, subject to the following conditions:

- the TWS *must be sanctioned* by the International Brotherhood of Teamsters;
- the Welfare Fund *must receive written confirmation of strike sanctioning* 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 previously terminated when the TWS begins; and
- unused Benefit Bank weeks will be applied from the inception date of the sanctioned TWS. After all your Benefit Bank weeks have been exhausted, coverage will continue during the sanctioned TWS.

If you have not established eligibility and are absent from employment due to a sanctioned TWS, coverage will be provided starting on the first Sunday of the week following completion of the eligibility period as though your employer had continued to make contributions during the TWS.

The extension of coverage during a sanctioned TWS will be reviewed monthly during the TWS. The Trustees have the right to disallow or terminate Plan coverage during all or part of any sanctioned TWS. However, if you are involved in a TWS before the Board makes its decision to disallow or terminate coverage, the decision will be applied only going forward. You will not lose coverage for any period(s) before the decision is made. When the Trustees disallow or terminate Plan coverage, if you have time in your Benefit Bank, your coverage will continue until your Benefit Bank runs out. After that, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 10.

DEATH

If you die, your eligible dependent's benefits will continue for as long as you have weeks remaining in your Benefit Bank. When your Benefit Bank runs out, your eligible dependents may be able to purchase continued medical coverage. See COBRA: Continuing Your Benefits, on page 10.

REINSTATEMENT

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 the Plan. Your coverage will start on the day you return to work with a contributing employer, as long as your employer is making contributions on your behalf. If you do not return to work within 26 weeks you will have to reestablish your eligibility as described on page 2.

If your 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 the 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 apply for reemployment with a contributing employer within 90 days of your discharge. (This deadline will be extended up to two years if you are hospitalized or convalescing because of a service-related illness or injury.) Coverage for you and your dependents will be reinstated on the day you return to work.

COBRA: CONTINUING YOUR BENEFITS

Under certain circumstances, you or your eligible dependents 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 and your dependents a right to this continuation of medical coverage under the Plan.

The continuation coverage will be identical to the medical coverage available under the Plan. You will be required to pay the full cost for the coverage you continue, plus an administrative charge. If, during a period of COBRA continuation coverage, you marry, have a newborn child, adopt a child, or otherwise add an eligible dependent, that dependent may be added to the coverage for the balance of the period of continuation coverage. Your payments for COBRA continuation coverage must be made on time or coverage will not be continued.

In some circumstances, you may be able to continue coverage for other benefits offered under the Plan. The continuation of these other benefits are not subject to the rules governing continuation of health coverage, however. You should contact the Welfare Fund Office for additional information about the continuation of other benefits.

WHEN COVERAGE CONTINUES FOR 18 MONTHS

You and your eligible dependents may elect continuation coverage for up to 18 months if coverage ends for one of the following reasons or “qualifying events:”

- your employment with a contributing employer terminates, including termination due to retirement, but not including termination due to gross misconduct;
- you are no longer eligible for coverage due to a reduction in your hours of work; or
- you are laid off by your employer (coverage may extend beyond 18 months if the recall provisions of your contract provide for this); or
- your Employer’s bankruptcy.

WHEN COVERAGE CONTINUES FOR 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 or one of your eligible dependents is totally disabled, the disabled person, as well as member(s) 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 or your dependents already have continued COBRA coverage for a period greater than 29 months, no additional extension will be granted because of disability.

YOU MUST NOTIFY THE WELFARE FUND OFFICE of the determination of disability by the Social Security Administration WITHIN 60 DAYS AFTER THE DETERMINATION.

WHEN COVERAGE CONTINUES FOR 36 MONTHS

Your eligible dependents may elect to continue coverage for up to 36 months if their coverage under the Plan ends for any of the following reasons or “qualifying events:”

- your death;
- your divorce; or
- your child no longer qualifies for dependent coverage under the terms of the Plan; or
- you become eligible for Medicare.

LOSS OF CONTINUED COVERAGE

COBRA continuation coverage may be cut short for any of the following reasons:

- you or your dependents become covered under another group medical plan. However, coverage may be continued if you or an eligible dependent have a health problem for which coverage is excluded or limited under the other group medical plan;
- your employer stops participating in the Welfare Fund. However, if you or an eligible dependent 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.
- the required contributions are not paid;
- the required contributions are not paid on time;
- the Plan is terminated;
- you or your dependents reach the end of the 18-month, 29-month or 36-month continuation coverage period;
- you become entitled to Medicare. However, if your eligible dependents are entitled to continued coverage, their maximum coverage period is 36 months; or
- your dependent(s) becomes entitled to Medicare.

NOTIFYING THE WELFARE FUND OFFICE

You or your eligible dependents are responsible for notifying the Welfare Fund Office if you divorce or your dependent 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 continuing coverage, whichever is later. If you fail to notify the Welfare Fund Office of your divorce or loss of dependent status within 60 days, you will lose the right to COBRA coverage.

You will be given an additional 45 days from the date you elect continued coverage to make any back payment necessary to avoid a gap in coverage. Payments for subsequent months are due at the end of the month prior to the month for which coverage is provided. For example, payment for June coverage is due by May 31st. Failure to remit the premium within 52 days of the payment due date will result in cancellation of all coverage.

To help ensure that you do not lose coverage, we recommend that you or a family member notify the Welfare Fund Office as soon as possible of any events that can cause your coverage to end.

CERTIFICATES OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires “Certificates of Creditable Coverage” to be issued when there is a loss of coverage. The certificate will show how long you were covered under this Plan.

If you lose coverage, the Welfare Fund will send you, along with a COBRA notice, 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 preexisting condition limitation period under that plan.

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

An additional certificate will automatically be provided within a reasonable period of time after your COBRA coverage stops. You can request a certificate at any time within the 24-month period after COBRA coverage stops. To request a Certificate of Creditable Coverage, please call ext. 375 at (313) 964-2400, or toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan.

This Plan does not have a preexisting condition exclusion.

DENTAL BENEFITS

CHOICE OF DENTAL PROVIDERS

You have a choice between receiving services from In-Network or Out-of-Network providers. The option you choose determines how you will receive your dental benefits. Refer to your Schedule of Benefits for how your Plan covers this benefit.

The In-Network option gives you and your family the widest scope of coverage. However, you must use the specific dental providers who have chosen to become Delta Dental of Michigan Network providers. Additional network dentists are available when you travel outside of the Michigan service area.

The Plan has entered into a fee arrangement with Delta Dental of Michigan, which is a network of dentists. Under this In-Network arrangement, the dentists accept agreed-upon fees as payment in full. Therefore, when services are rendered by dentists within the network, or In-Network providers, you are only responsible to paying your coinsurance amount that is listed in your Schedule of Benefits. You are also responsible for procedures that you request that are not covered.

The Out-of-Network option provides a narrower scope of benefits with higher out-of-pocket costs, but allows you to use the dental providers of your choice. You may choose to use dentists that are not in the network, or Out-of-Network providers. Because the Welfare Fund 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 the Plan's fee schedule, you will be responsible for paying the balance. When you use Out-of-Network providers, you must pay any balance over and above the fee schedule. You should refer to your Schedule of Benefits to determine how Out-of-Network benefits are paid.

Your choice of receiving dental care from an In-Network or Out-of-Network provider is completely voluntary. You may switch between In-Network and Out-of-Network dental providers and each claim will be paid according to which provider you have chosen.

The Welfare Fund Office is required to furnish you automatically without charge, a separate document listing In-Network dentists. This listing is referred to as the participating provider directory. To obtain a directory or to find out if your current dentist is an In-Network provider, you may call the Welfare Fund Office at (313) 964-2400, or toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan. You may also visit the Michigan Conference of Teamsters Welfare Fund's website, www.mctwf.org to link to the Delta Dental website to obtain up-to-date listings of In-Network providers.

IN-NETWORK OPTION

Your Plan will pay the full cost of covered dental procedures that you and your eligible dependents require, except orthodontia, when dental services are rendered by an In-Network provider. There is no annual dollar maximum, but there are annual benefit maximums. For instance, the examination benefit is limited to two times each calendar year.

Covered Dental Expenses

In-Network covered dental services and supplies include, but are not limited, to:

- oral examination, cleanings and scalings twice per calendar year;
- full mouth x-rays every three years;
- bitewing x-rays twice per calendar year;

- laboratory and diagnostic tests;
- fluoride treatments twice per calendar year for dependents up to age 14;
- oral surgery;
- emergency palliative treatment;
- endodontics;
- space maintainers;
- extractions, root canals and fillings;
- onlays, crowns, bridgework, dentures and other prosthetics; and
- periodontics.

Covered Orthodontic Expenses

If you or your eligible dependents require orthodontic treatment, you will share in the cost of the treatment.

The orthodontic copayment applies separately to you and each eligible dependent for each course of treatment. The Plan will continue to pay benefits as long as you remain covered and eligible under the Plan.

No Claim Forms

When you call the In-Network provider for an appointment, you will be asked to provide your social security number. The provider may verify that you are eligible before your visit. You do not have to complete a claim form when you and your dependents receive treatment at an In-Network provider.

OUT-OF-NETWORK OPTION

If you choose the Out-of-Network option, covered services and supplies are paid according to a Fee Schedule. You will be responsible for paying any difference between the cost of the service and the amount paid by the Plan.

The Plan will pay a percentage of orthodontic charges for each of your dependent children under age 19. There is a lifetime maximum benefit per person, which is shown in your Schedule of Benefits.

Out-of-Network Fee Schedule

Dental benefits are paid according to a Fee Schedule. The table on page 16 lists the most commonly used services or procedures and their American Dental Association (ADA) Code. The table is not a complete list used by the Plan. If a procedure is not listed, you or your dentist may call the Welfare Fund Office's Member Services Department at (313) 964-2400 to receive a quote for the maximum allowable fee for that procedure. You may also call toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan. Please be prepared to provide the ADA Code to Member Services when calling for the quote.

*Code Description for the following table:**A/H: considered a medical procedure and therefore not covered under your dental plan.**N/P: not a covered benefit.**I.C.: fee subject to individual consideration; you may call the Welfare Fund Office for the fee*

ADA Code	Procedure Description	Maximum Payment
Diagnostic 100-999		
0120	Periodic oral evaluation	\$24
0110/0150	Complete oral evaluation	\$36
0130/0140	LTD oral exam-problem focused, emergency	\$35
0210	Intraoral-complete series (includes bitewings)	\$70
0220	Intraoral-Periapical-first film	\$13
0230	Intraoral-Periapical-each additional film	\$10
0240	Intraoral-Occlusal film	\$20
0270	Bitewing-single film	\$15
0272	Bitewings-two films	\$23
0274	Bitewings-four films	\$30
0330	Panoramic film	\$65
0340	Cephalometric film	A/H
0460	Pulp Vitality tests	\$36
0470	Diagnostic casts	N/P
0471	Diagnostic photographs	N/P
Preventive 1000-1999		
1110	Prophylaxis-adult (twice per year)	\$45
1120	Prophylaxis-child (twice per year)	\$32
1201	Topical applic fluoride (includes prophylaxis)-child	\$61
1203	Topical applic fluoride (prophylaxis not included)-child	\$20
1204	Topical applic fluoride (prophylaxis not included)-adult	N/P
1205	Topical applic fluoride (includes prophylaxis)-adult	N/P
Restorative 2000-2999		
2110	Amalgam-1 surface prim	\$41
2120	Amalgam-2 surfaces prim	\$52
2130	Amalgam-3 surfaces prim	\$62
2140	Amalgam-1 surface permanent	\$45
2150	Amalgam-2 surfaces permanent	\$58

ADA Code	Procedure Description	Maximum Payment
2160	Amalgam-3 surfaces permanent	\$ 70
2161	Amalgam-4/more surfaces permanent	\$ 85
2330	Resin-1 surface anterior	\$ 55
2331	Resin-2 surfaces anterior	\$ 70
2332	Resin-3 surfaces anterior	\$ 85
2335	Resin-4/more surfaces/involves incisal angle anterior	\$101
2380	Resin-1 surface post-prim	\$ 62
2381	Resin-2 surfaces post-prim	\$ 73
2385	Resin-1 surface, posterior permanent	\$ 61
2386	Resin-2 surfaces post-perm	\$ 85
2387	Resin-3/more surfaces post-perm	\$105
2740	Crown-porcelain/ceramic substrate	\$497
2750	Crown-porcelain fused to high noble metal	\$490
2751	Crown-porcelain to predominantly base metal	\$457
2752	Crown-porcelain fused to noble metal	\$468
2790	Crown-full cast high noble metal	\$473
2791	Crown-full cast predominantly base metal	\$448
2792	Crown-full cast noble metal	\$457
2920	Recement crown	\$ 45
2930	Prefab stainless steel crown-prim tooth	\$154
Endodontic 3000-3999		
3110	Pulp Cap-Direct (excludes final restoration)	\$ 29
3120	Pulp Cap-Indirect (excludes final restoration)	\$ 23
3220	Therapy pulpotomy (excludes final restoration)	\$ 77
3310	Ant (excludes final restoration) (root canal)	\$287
3320	Bicuspid root canal (excludes final restoration) (root canal)	\$351
3330	Molar (excludes final restoration) (root canal)	\$453
Periodontics 4000-4999		
4211	Gingivectomy/gingivoplasty per tooth	\$ 67
4220	Gingival curettage surg per quadrant br	\$155
4260	Osseous surg (includes flap entry & close)-per quad	\$473
4271	Free soft tissue gft proc (includes donor site surg)	\$360

ADA Code	Procedure Description	Maximum Payment
4341	Periodontal scaling/root planing-per quad	\$125
4355	Full mouth debrid-enable periodontal eval & dx	\$134
4910	Periodontal maintenance procedure (following active therapy)	\$ 75
Prosthodontics, removable 5000-5899		
5110	Complete denture-maxil	\$601
5120	Complete denture-mandib	\$601
5213	Maxil part denture-cast metal frame w/resin base	\$664
5214	Mandib part denture-cast metal frame w/resin base	\$664
5640	Replace broken teeth-per tooth	\$ 66
5650	Add tooth to existing part denture	\$ 90
Prosthodontics, fixed 6200-6999		
6240	Pontic-porcelain fused to high noble metal	\$438
6241	Pontic-porcelain fused to predominantly base metal	\$404
6242	Pontic-porcelain fused to noble metal	\$427
6750	Crown-porcelain fused to high noble metal	\$500
6751	Crown-porcelain fused to predominantly base metal	\$466
6752	Crown-porcelain fused to noble metal	\$478
6930	Recement fixed partial denture	\$ 59
Oral Surgery 7000-7999		
7110	Single tooth (extraction)	\$ 58
7120	Each additional tooth (extraction)	\$ 54
7210	Remove erupt tth-w/mucoperiostl flap-remov bne/tth	\$114
7220	Remove impacted tooth-soft tissue	\$143
7230	Remove impacted tooth-part bony	\$190
7240	Remove impacted tooth-complete bony	\$280
7250	Surg remove residual tooth roots (cutting proc)	\$120
7310	Alveoplasty w/extractions-per quadrant	\$133
7510	I&D ABSC-intraoral soft tissue	A/H
Adjunctive General Services 9000-9999		
9110	Palliative (ER) Tx dental pain-minor proc	\$ 48
9220	Gen anes-first 30 min	I.C.
9221	Gen anes-each add 15 minutes	I.C.

IF YOU DO NOT HAVE ACCESS TO IN-NETWORK PROVIDERS

In the event you live further than 20 driving miles (as determined by the Welfare Fund) from a Delta Dental general dentist and therefore do not have adequate access to the Welfare Fund's Delta Dental Network, you will have the option of seeking care from a dentist of your choice. To do so, you must apply for an exemption to use an Out-of-Network provider (see below). You will receive a separate Schedule of Benefits, subject to verification and approval of the Welfare Fund. Approval for the exemption to use Out-of-Network providers will be made on a per-claim basis. Upon approval of the application for the exemption, the claim should be submitted to the Welfare Fund Office. Please note that specialists, other than orthodontists (see below) are not covered under this rule.

If you have an exemption to use an Out-of-Network provider, your dental benefits are payable at the In-Network level. Payment will be made to you, not your Out-of-Network dentist. However, since the Out-of-Network dentist does not have an agreement with Delta Dental or the Welfare Fund, you will be responsible for any balance over and above the Welfare Fund's payment.

Orthodontics

In the event you live further than 25 driving miles (as determined by the Welfare Fund) from a Delta Premier orthodontist and therefore do not have adequate access to the Welfare Fund's Delta Dental Network, 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 below). You will receive a separate Schedule of Benefits, subject to verification and approval of the Welfare Fund.

If you have an exemption to use an Out-of-Network provider, your benefits are payable at the In-Network level, or the Welfare Fund's scheduled amount, whichever is less, subject to prior authorization through Delta Dental. You will be notified of the benefits by Delta Dental. Payment will be made to you, not your Out-of-Network orthodontist. However, since the Out-of-Network orthodontist does not have an agreement with Delta Dental or the Welfare Fund, you will be responsible for any balance over and above the Welfare Fund's payment.

A course of orthodontic treatment can last from a few months to several years. Your exemption will remain valid for the entire treatment plan even if an In-Network orthodontist becomes "accessible" to you during the course of treatment. If your orthodontist joins the network during the course of treatment, In-Network benefits will be provided for the remainder of the treatment.

Application for Exemption If You Do Not Have Access to In-Network Providers

To apply for an exemption to use Out-of-Network providers, call the Welfare Fund's Member Services Department at (313) 964-2400 or toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan.

HOW TO FILE A CLAIM

To receive Out-of-Network benefits, you must submit a complete itemized bill to the Welfare Fund Office. Out-of-Network benefits will be paid directly to you.

All claims for benefits must be FILED WITHIN ONE YEAR from the date the eligible expense is incurred. If the Welfare Fund requests additional information from you or your provider with regard to your claim, you have one year from the date of the request to respond.

If your claim is denied, you can follow the appeals process described in this booklet.

PREDETERMINATION OF BENEFITS

Predetermination of benefits allows you to know what benefits the Plan will pay 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 may submit a treatment plan for review by the Welfare Fund before any dental procedures are performed, including those procedures listed below:

Prosthodontics	Periodontics	Oral Surgery
Onlays	Subgingival Curettage	All oral surgical procedures except four or fewer simple extractions
Crowns	Surgical Periodontics	
Space Maintainers		
Bridges		
Removable Full or Partial Dentures		

Obtaining a Predetermination of Benefits

Follow these steps to obtain a predetermination of benefits before you or your eligible dependents receive treatment for those dental procedures listed above:

- Give your dentist a dental claim form. You may obtain claim forms from the Welfare Fund Office by calling the Welfare Fund's Member Services Department at (313) 964-2400, or toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in Upstate Michigan or (800) 334-9738 Outside of Michigan.
- Have your dentist complete the form showing the proposed treatment and costs. Your dentist should then mail the completed form to the Welfare Fund Office.
- Both you and your dentist will receive a statement of predetermination showing the amount that the Plan will pay 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. Payment of benefits will be contingent upon your current eligibility on the day the services are completed.
- Like any other claim, the Plan's coordination of benefits provision will apply when you submit a claim for payment for the work actually performed. See the Coordination of Benefits section on page 26 for an explanation of the coordination of benefits provision.

DENTAL EXPENSES NOT COVERED

In addition to the items shown in the Exclusions and Limitations section of your Summary Plan Description, the following types of services and care are not covered by the Plan:

- appliances, restorations or services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ) (This may be covered under your 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;
- accidental injury to sound natural teeth (This may be covered by your medical benefits plan, depending on the benefits negotiated.);
- charges for sealants;
- charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
- implantology, including implants and appliances constructed for implanting, the surgical removal of implants;
- 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;
- charges for completion of claim forms or missed appointments;
- charges that you are not legally required to pay;
- expenses for root canal treatment and/or apicoectomies when previously paid;
- expenses for services or appliances started before the effective date of coverage under the Plan;
- expenses for replacement made less than five years after placement or replacement that was covered by this Plan or a predecessor plan;
- general anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless medically necessary;
- services for injuries or conditions payable under auto-related, third-party liability, workers' compensation or employer's liability laws;
- 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 this Plan incurred in new extended areas;
- replacement due to loss or theft;
- orthodontic expenses for the member or spouse, if provided by an Out-of-Network provider;
- dental services or treatments that are not included in the Out-of-Network Fee Schedule of Dental Benefits, if services are provided by an Out-of-Network dentist;
- 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; and
- services as determined by the Welfare Fund for correction of congenital or developmental malformations, cosmetic surgery or dentistry for aesthetic reasons.

ALTERNATE PROCEDURES

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

For example, if an amalgam filling could restore a tooth, but you and your dentist decide to use a gold filling, the Plan will pay only the amount it would have paid for the amalgam filling. You must pay the difference in cost.

OPTICAL BENEFITS

COVERED EXPENSES

Covered optical expenses are the charges you or your dependents are required to pay for a vision examination and prescribed lenses and frames or contact lenses. The examination must be given by a licensed ophthalmologist or optometrist. The Plan pays up to a scheduled amount for each covered service or supply. See your Schedule of Benefits for:

- the amounts allowed; and
- the frequency of treatment allowed.

The Plan does not have a network of optical providers.

NOT COVERED

In addition to the items shown in the Exclusions and Limitations section of your SPD, the following are not covered:

- services or supplies to correct a vision defect that happens as the result of a work- or auto-related injury or illness;
- services or supplies received from an optical department maintained by a mutual benefits association, labor union or other similar group;
- if you or your dependent are covered both as an employee and as a dependent or as a dependent of two employees under these or any other optical care benefit provisions, then the benefit frequency limitations outlined in your Schedule of Benefits will apply as if you or your dependent were covered as an employee or as a dependent only;
- any expense you or your dependent incur that you are not legally required to pay;
- replacement due to loss or theft;
- vision services or supplies received more frequently than allowed in your Schedule of Benefits;
- treatment given by someone who is not a licensed optometrist or ophthalmologist;
- any service or procedure not specifically included or limited in the Schedule of Benefits;
- any medical or surgical treatment of the eye or refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK);
- sunglasses, plain or prescription, or safety lenses or goggles, tinting or photochromic lenses;
- orthoptics, vision training or aniseikonia;
- charges for completion of claim forms or missed appointments;
- repairs of any kind; and
- claims for benefits submitted after the Plan's one-year filing limitation.

HOW TO FILE A CLAIM

Obtain an optical claim form from the Welfare Fund Office.

You must complete the **Employee** section of the form. Your optical care provider should complete the rest of the form and mail it to the Welfare Fund Office.

If you have not paid the bill, the Welfare Fund will pay benefits directly to your optical care provider. If you have paid the bill, you will receive payment from the Welfare Fund for the amount that is covered by the Plan. In either case, you will receive a statement explaining what has and has not been paid. You must pay the difference in cost, if any, between the billed amount and the amount paid by the Plan.

All claims for benefits must be FILED WITHIN ONE YEAR from the date the eligible expense is incurred. If the Welfare Fund requests additional information from you or your provider with regard to your claim, you have one year from the date of the request to respond.

APPEAL PROCEDURE IF YOUR CLAIM FOR BENEFITS IS DENIED

The Welfare Fund's Board of Trustees has full and absolute discretion, authority and power to interpret the terms of the Plan, determine all questions of coverage and eligibility and decide benefit claims.

If you are affected by an adverse claim determination, you are entitled to an appeal and may initiate an appeal through a written request to the Board of Trustees at the following address:

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

Appeal decisions will be made solely upon written submissions. Your written request for review of a claim must be submitted within 60 days after the date the notice of the claim denial was sent to your last known address. The request must set forth the basis for the appeal and all pertinent information to support your position. In connection with the appeal, you may inspect copies of pertinent documents upon which the claim denial was based.

A written appeal decision will be rendered within 60 days of the Welfare Fund's receipt of the appeal. If special circumstances require an extension of time for processing by the Welfare Fund, written notice of the extension will be furnished to you within the initial 60-day period. The extension will not exceed an additional 60 days. If additional information from you is necessary in order to fully review the appeal, the Welfare Fund will request it in writing. You must respond to the Welfare Fund's request within 90 days after the date of the request. A written appeal decision will be rendered within 60 days after the Welfare Fund receives the requested information from you. If the Welfare Fund does not receive a response from you within 90 days, a written appeal decision will be rendered within 60 days based upon the information in the file at that time.

The written appeal decision will state the specific reasons for the decision and will provide specific references to the pertinent benefits/Plan provisions on which the decision is based.

The Welfare Fund has two levels of appeal:

- **First Level.** The Board of Trustees has delegated to the Appeals Committee the authority to approve or deny first level appeals. If you are not satisfied with the first level appeal decision, you may file a second level appeal.
- **Second Level.** The Board of Trustees decides all second level appeals. The decision by the Board of Trustees to approve or deny your second level appeal will be final, conclusive and binding.

You are required to exhaust both levels of the Welfare Fund's Appeal Procedure before commencing legal action in state or federal court.

ANY LAWSUIT OR LEGAL ACTION CONCERNING A CLAIM FOR BENEFITS MUST BE COMMENCED WITHIN TWO YEARS FOLLOWING THE CONCLUSION OF THE CLAIMS REVIEW PROCEDURE, UNLESS THE CLAIMS REVIEW PROCEDURE WAS COMPLETED BEFORE APRIL 1, 1999. FOR CLAIMS REVIEW PROCEDURES COMPLETED BEFORE APRIL 1, 1999, THE MICHIGAN STATE LAW LIMITATIONS PERIOD APPLICABLE TO CONTRACTS APPLIES TO LAWSUITS OR LEGAL ACTIONS CONCERNING CLAIMS FOR BENEFITS.

RIGHT TO RECOVERY

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

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

You are required to provide the Welfare Fund with any instructions and papers that may be necessary to recover over payments.

You must return any payments to the Welfare Fund that are not required under the terms of the Plan. The Welfare Fund has the right to recover overpayments by deducting the overpayment amount from your future benefits.

SUBROGATION AND REIMBURSEMENT

When the Welfare Fund pays any benefits for you or your dependents, the Welfare Fund immediately gains all rights of recovery against any person or entity that caused or contributed to the loss covered by the Welfare Fund. This is called subrogation. In addition, if you or your dependent receives any payment from any party as a result of an injury, the Welfare Fund has the right to reimbursement from you or your dependent for all amounts the Welfare Fund has paid and will pay as a result of that injury from any amounts you or your dependent receives from any party. The Welfare Fund will be entitled to reimbursement out of any monies you or your dependent receives, whether or not those monies are designated as reimbursement for medical expenses.

You and your dependent and those acting on your behalf, including attorneys:

- may do nothing to prejudice the Welfare Fund's subrogation and reimbursement rights;
- must provide the Welfare Fund with information when requested;
- must cooperate with the Welfare Fund in the enforcement of the Welfare Fund's subrogation and reimbursement rights; and
- must notify the Welfare Fund of your intention to pursue a claim to recover damages on your behalf by the later of:
 - > the date the party (or the party's attorney) is notified of the intent to pursue damages; or
 - > 45 days after the date of your or your dependent's injury.

The Welfare Fund's subrogation and reimbursement rights are a first priority claim against all potentially liable parties. The Welfare Fund is to be paid before any other claim for general damages for you or your dependent. The Welfare Fund is entitled to subrogation and reimbursement even if the payments received from any or all parties are insufficient to compensate you or your dependent for the damages sustained. The Welfare Fund's right to subrogation and reimbursement is not limited by any right you or your dependent has to be made whole. The Welfare Fund is not required to participate in any damage claim or pay attorneys' fees to any attorney you or your dependent hires to pursue the damage claim.

This subrogation and reimbursement provision applies whether or not liability for payment is admitted by a third party. If you or your dependent refuse to reimburse the Welfare Fund in accordance with the terms of this provision, the Welfare Fund has the right to deduct the amount of benefits paid from any future benefits payable to, or on behalf of, you or your dependent.

You or your dependent may receive reimbursement for medical services before benefits are paid under the Welfare Fund. In that case, the benefit payable by the Welfare Fund will be limited to the amount of benefits in excess of the reimbursed amount, if any. Reimbursement means all direct or indirect payments to, or on behalf of, you or your dependent for injury or illness from any source by settlement, judgment or any other means.

COORDINATION OF BENEFITS

Occasionally, an individual who is entitled to receive benefits under this Plan will also be eligible for similar benefits under another group health plan.

If you or your eligible spouse has coverage under another group health plan, benefits under this Plan will be coordinated with benefits under the other plan. Plans for which benefits will be coordinated include:

- government insurance plans provided for or required by law; and
- group insurance plans, such as those provided by your spouse's employer.

When you submit a claim for benefits, the *primary plan* pays applicable covered expenses first. The *secondary plan* pays the remaining covered expenses. The *secondary plan* adjusts the benefits it pays so that the benefits are not greater than the coverage allowed by the *secondary plan*.

A group benefit plan that does not have a Coordination of Benefits provision is always the *primary plan*. If all benefit 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 a dependent will be the *primary plan* (for example, if your spouse needs a medical procedure and is covered by a medical plan provided by his or her employer, his or her employer's plan is the *primary plan*).
- If your dependent children are covered by this Plan and your spouse's plan, the *primary plan* is the plan of the child's parent whose birth date (not including year of birth) occurs earlier in a calendar year.

If the *primary plan* cannot be determined based on these rules, the plan that has covered the patient for the longest period of time will be the *primary plan*.

If the parents are divorced or separated, dependents' coverage is provided as follows:

- When a court decree has established which parent has financial responsibility for the child's health care expenses, then that parent's plan will be the *primary plan*.
- When financial responsibility has not been established, the plan of the parent with custody is the *primary plan*.
- If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of benefit determination is as follows:
 - > 1st – the plan of the parent with custody;
 - > 2nd – the plan of the stepparent with custody;
 - > 3rd – the plan of the parent without custody.

Example

As an example of coordination of benefits, assume that:

- your spouse has a dental procedure costing \$100;
- your spouse is eligible under another dental plan, which is the *primary plan*;
- the *primary plan* will cover \$75 of this procedure; and
- this Plan will cover \$90.

The Plan will pay the balance of this claim or the Plan's scheduled amount, whichever is less. Therefore, you would receive \$75 in benefits from the primary plan and an additional \$90 in benefits from this Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

As permitted by law, the Welfare Fund reserves the right to release or obtain any information about you or your covered dependents 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 this Plan, you will be required to provide any necessary information to the Welfare Fund.

NON-ALIENATION OF BENEFITS

Your benefits under the Retiree Welfare Fund may not be assigned or seized to pay your debts unless:

- you have voluntarily assigned your benefit to pay a health care provider for services covered under the Retiree Welfare Fund; 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 the Retiree Welfare Fund's right to recover overpayments it made to you or on your behalf.

YOUR RIGHTS UNDER ERISA

As a participant in the Michigan Conference of Teamsters Welfare Fund Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

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 the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the 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 the 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.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other 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 exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit 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 the Plan documents or the latest annual report from the 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 the 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 the 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 the 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 Plan fiduciaries misuse the 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.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the 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 the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration. For single copies of publications, contact the Pension and Welfare Benefits Administration Brochure Request Line at (800) 998-7542 or contact the PWBA field office nearest you.

You may also find answers to your Plan questions at the website of the PWBA at <http://www.dol.gov/dol/pwba/>. A list of PWBA Field Offices is located at <http://www.dol.gov/dol/pwba/public/contacts/folist.htm#TOF>.

PLAN ADMINISTRATION INFORMATION

The following material provides information about how the Plan is administered.

Name and Address of Plan

Michigan Conference of Teamsters Welfare Fund Plan
2700 Trumbull Avenue
Detroit, Michigan 48216
(313) 964-2400
Toll free at:
(800) 572-7687 in the Metro-Detroit area
(800) 824-3158 in Upstate Michigan
(800) 334-9738 Outside of Michigan

Plan Sponsor

Trustees of the Michigan Conference
of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, Michigan 48216
(313) 964-2400
Toll free at:
(800) 572-7687 in the Metro-Detroit area
(800) 824-3158 in Upstate Michigan
(800) 334-9738 Outside of Michigan

Employer Identification Number (EIN)

38-1328578

Plan Number

501

Type of Welfare Plan

This Plan provides dental and optical benefits. The Plan is self-insured by the Michigan Conference of Teamsters Welfare Fund.

Type of Plan Administration

The Plan is administered by the Trustees.

Plan Administrator

Trustees of the Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, Michigan 48216
(313) 964-2400
Toll free at:
(800) 572-7687 in the Metro-Detroit area
(800) 824-3158 in Upstate Michigan
(800) 334-9738 Outside of Michigan

Plan Trustees

The following individuals are Trustees of the Plan:

Union Trustees

William A. Bernard
 President, Local 164 I.B.T.
 3700 Ann Arbor Road
 Jackson, Michigan 49202

Robert F. Rayes
 President, Local 51 I.B.T.
 2741 Trumbull Avenue
 Detroit, Michigan 48216

H.R. Hillard
 Business Representative
 Local 337 I.B.T.
 2801 Trumbull Avenue
 Detroit, Michigan 48216

Employer Trustees

Robert J. Lawlor
 16001 Knollwood Drive
 Dearborn, Michigan 48120

Howard McDougall
 1300 East Big Beaver
 Troy, Michigan 48083

Raymond J. Buratto
 Managing Director
 Motor Carriers Employers' Association
 3128 Walton Boulevard, Suite 270
 Rochester Hills, Michigan 48309

Collective Bargaining Agreements

The Plan is maintained according to a number of collective bargaining agreements. For information on obtaining or examining a copy of your collective bargaining agreement, contact your Local Union.

Sources of Contributions to the Plan

Contributions are made by employers according to the terms of applicable collective bargaining agreements or participation agreements. In certain circumstances, Plan participants are permitted to make contributions to the Plan.

Funding Method

The Plan is funded by contributions from employers and from investment income.

Plan Year

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

Agent For Service of Legal Process

For disputes arising under the Plan, service of legal process may be made on the Executive Director, Plan Administrator or any individual Trustee at the Welfare Fund Office.

Administrative Services

Blue Cross Blue Shield of Michigan (BCBSM) provides certain administrative services under the Plan. Its address is:

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

BCBSM is not authorized to make final benefit claim decisions under the Plan. Questions concerning claims or benefits under the Plan should be sent to the Welfare Fund Office.

Employment Rights Not Guaranteed

Your eligibility for, or participation in, the Plan does not guarantee your rights to benefits other than those specified in the Master Plan Document, nor does it guarantee your employment rights with a contributing employer.

Plan Amendment

The provisions of your Plan may be amended from time to time 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 the Plan can be made 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 the 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 the Plan.

Plan Termination

The Plan may be terminated for any reason permitted under ERISA and the terms of the Trust Agreement. In the event of Plan termination, the Trustees will notify the union and employers and 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 any and all obligations of the Plan. 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 the Plan, 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 the Plan. Upon termination, no part of the assets of the Plan 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 the Welfare Fund 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 Welfare Fund coverage and eligibility;
- methods of providing benefits;
- all matters concerning the operation of the Welfare Fund; and
- all claims for benefits.

Benefits under this Plan will be paid only if the Trustees decide in their discretion that

IMPORTANT DEFINITIONS

The following definitions relate to dental services:

Bitewing X-Rays Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework

Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Removable: A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis.

Course of Treatment The planned program of one or more services or supplies, provided by one or more Dentists to treat a dental condition diagnosed by the attending Dentist as a result of an oral examination. The course of treatment begins when a Dentist first renders a service to correct or treat the diagnosed dental condition.

Crown The portion of a tooth covered by enamel.

Dental Hygienist A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who:

- acts within the scope of his or her license; and
- is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dentist A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who:

- is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and
- acts within the scope of his or her license; and
- is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture A device replacing missing teeth.

Fluoride A solution applied to the surface of teeth to prevent dental decay or a prescription drug (usually in pill form) used for the same purpose.

Implantology The science of placing artificial root structures on or within the jawbones that will act to hold and support a dental prosthesis.

Impression A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Inlay A Restoration made to fit a prepared tooth cavity and then cemented into place. (See the definition of restoration.)

Onlay An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Orthodontics, Orthodontia The science of the movement of teeth in order to correct a malocclusion or “crooked teeth.”

Prophylaxis The removal of tartar and stains from the teeth by cleaning and scaling of the teeth, performed by a Dentist or Dental Hygienist.

Prosthesis (Dental) An artificial replacement of one or more natural teeth and/or associated structures.

Restoration A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Root Canal (Endodontic) Therapy Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale To remove calculus (tartar) and stains from the teeth with special instruments.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.