SUMMARY PLAN DESCRIPTION

Michigan Conference
of Teamsters Welfare Fund
Summary Plan Description

PEP

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).

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

(313) 964-2400 ext. 428	Prior authorization of Hospice Care and Home Health Care
(800) 572-7687 ext. 428	Toll free Metro-Detroit
(800) 824-3158 ext. 428	Toll free Upstate Michigan
(800) 334-9738 ext. 428	Toll free Outside of Michigan

(800) 482-4040	Prior authorization of Skilled Nursing Facility Care

(800) 457-8540	Prior authorization of treatment for Mental and Nervous Conditions and Substance Abuse

(800) 242-3504	Prior authorization of Human Organ Transplant Procedures

(800) 445-6417	Prior authorization of all other hospital admissions

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.

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INTRODUCTION

This booklet is a Summary Plan Description (SPD) of your Plan in effect as of July 1, 2001. The PEP Plan is a group health plan that provides health and welfare 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 8) 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 8.
- 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:

- are receiving Weekly Accident & Sickness Benefits; or
- are eligible to purchase continued coverage (see COBRA: Continuing Your Benefits, on page 9) and you make the required payments on time.

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 9.

Layoff

If you are laid off, your employer will stop making contributions to the Welfare Fund on your behalf. However, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 9.

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. However, you may be able to purchase continued coverage. See COBRA: Continuing Your Benefits, on page 9.

ILLNESS

If you are unable to work because you are ill, your employer may stop making contributions to the Welfare Fund on your behalf. However, if you are receiving Weekly Accident & Sickness Benefits from this Plan, your coverage will continue for as long as that benefit is being paid. Please refer to the section on Weekly Accident & Sickness Benefits, on page 42.

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; and
- coverage *will not* be provided if you are on leave of absence, sick leave, layoff, or have been previously terminated when the TWS begins.

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, you may be able to purchase continued coverage. See COBRA: Continuing
Your Benefits, on page 9.

DEATH

If you die, your eligible dependents may be able to purchase continued medical coverage. See COBRA: Continuing Your Benefits, on page 9.

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.

BASIC HOSPITAL/MEDICAL/SURGICAL BENEFITS

"IN-NETWORK" AND "OUT-OF-NETWORK" PROVIDERS

The Welfare Fund has entered into fee arrangements with Preferred Provider Organizations (PPOs), which are networks of hospitals, doctors and other health care providers. Under these arrangements, the hospitals and health care providers accept agreed-upon fees as payment in full. Therefore, when you use the services of hospitals or health care providers within a network, or "In-Network" providers, you are only responsible to pay your copayment amount that is 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 the Welfare Fund 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 Reasonable and Customary amount paid by the Plan, you will be responsible
to pay the balance of the bill. When you use Out-of-Network providers, you must pay the deductible and copayment that is listed in your Schedule of Benefits. Reasonable and Customary amounts and your deductible and copayment will be explained on the Explanation of Benefits form that you receive from the Plan for each claim payment. You should also refer to your Schedule of Benefits to determine how Out-of-Network benefits are paid. You may switch between In-Network and Out-of-Network providers as often as you choose.

The Welfare Fund Office is required to furnish you automatically and without charge, a document listing physicians and other health care providers. This listing is referred to as the participating provider directory. You may also visit the Michigan Conference of Teamsters Welfare Fund's website, *www.mctwf.org*, to link to the PPOM and Blue Cross Blue Shield of Michigan (BCBSM) websites to obtain up-to-date listings of In-Network hospitals and health care providers.

IF YOU DO NOT HAVE ACCESS TO IN-NETWORK PROVIDERS

Medical Primary Care

The Welfare Fund is dedicated to providing its participants and their families with affordable health care within their communities. If you live further than 20 driving miles (as determined by the Welfare Fund) from an In-Network Primary Care Physician (PCP) and therefore, do not have adequate access to In-Network benefits, you have the option of seeking care from a physician of your choice. To do so, you must apply for an exemption to use Out-of-Network providers (see the following Section). You will receive a separate Schedule of Benefits, subject to verification and approval by 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 exemption, the claim should
be submitted to the Welfare Fund Office.

Primary Care Physicians (PCPs) are doctors whose main area of care is Family Practice, Internal Medicine, General Practice, Pediatrics or Obstetrics/Gynecology. Please note that specialists are not covered under this rule.

Under the rules governing your coverage if you do not have access to In-Network providers, your benefits will be subject to the same deductible and copayments that apply to In-Network benefits. 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 over and above the Welfare Fund's Reasonable and Customary reimbursement levels.

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

You must apply for an exemption to use Out-of-Network providers if you do not have access to In-Network providers. To obtain an exemption application form, call the Welfare Fund's Member Services Department at (313) 964-2400, or toll free (800) 572-7687 in Metro-Detroit, (800) 824-3158 in Upstate Michigan, or (800) 334-9738 Outside of Michigan. Forms will also be available at the Welfare Fund Office.

SCHEDULE OF BENEFITS

Additional information about the Plan, including deductibles and copayments, is shown in the Schedule of Benefits that is included as part of this Summary Plan Description.

USING YOUR BLUE CROSS BLUE SHIELD CARD

Blue Cross Blue Shield of Michigan processes certain types of benefit claims under the Plan. Blue Cross Blue Shield of Michigan does not insure any benefits under the Plan.

You should present your Blue Cross Blue Shield of Michigan card (BCBSM) at the time you receive services for the following:

- inpatient and outpatient services performed at a hospital;
- ambulance service; and
- prescriptions filled at participating pharmacies.

When you present your card for these services, bills for the services will be sent directly to Blue Cross Blue Shield of Michigan for processing. Claims for services rendered by all other providers must be submitted to the Welfare Fund Office. See page 46 for information about filing claims for medical benefits.

YOUR HOSPITAL BENEFITS

The Plan covers 100% of the eligible expenses of hospital semi-private room and board for up to 365 days for treatment of a general medical condition. Expenses for a private room will be covered if medically necessary and recommended by your doctor. 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.

Multiple Admissions

If you are discharged from the hospital and must be readmitted for treatment of the same condition before returning to work, the two periods of hospitalization will be added together to determine the number of days of hospitalization. If you return to work for more than 14 days and are readmitted, your second hospital stay will be considered a separate admission. Hospital stays for dependents must be separated by at least six months to be considered separate admissions.

Substance Abuse Hospital Treatment

Substance abuse treatment in a hospital is limited to a 42-day lifetime maximum including confinements that may have occurred under any other Plan offered by the Welfare Fund.

Mental and Nervous Disorders Hospital Treatment

Hospital treatment for mental and nervous disorders is covered for a specified number of days per confinement. To be considered a separate confinement a 60-day period of non-confinement must separate each hospital stay. Admissions not separated by 60 days are counted as one admission toward the maximum number of days.

Other Hospital Services

The Plan allows benefits for the following hospital services provided by the hospital, hospital staff member or prescribed by your doctor while you are confined as an inpatient:

- 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; and
- use of radium, when owned and operated by the hospital.

Prior Authorization

ALL admissions for mental and nervous disorders and **substance abuse** as well as **hospice care, home health care, skilled nursing facility care, the purchase of durable medical equipment** and **orthotics must be approved in advance by the Welfare Fund.** Notification of the Welfare Fund's decision will be provided.

If prior authorization is not obtained, the Plan **may not provide benefits** for these expenses.

Prior authorization for **admissions for mental and nervous disorder** and **substance abuse** can be requested by calling (800) 457-8540. Approval for **hospice care** and **home health care** can be requested by calling ext. 428 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. Prior authorization for **skilled nursing facility care** can be requested by calling (800) 482-4040. Prior authorization for the purchase of **durable medical equipment** and **orthotics** can be requested by calling (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.

All other inpatient admissions must be preauthorized by calling (800) 445-6417.

OUTPATIENT AND SPECIAL INPATIENT SERVICES

Physician Outpatient Clinic Visits

The Plan will pay 100% of eligible expenses after you have paid the copayment that is required by your Schedule of Benefits for any non-emergency physician outpatient hospital clinic visits.

Emergency Services

The Plan pays eligible expenses for emergency room treatment for accidental injuries and life threatening medical emergencies that are not related to or caused by your job or that are not auto-related. The amount that the Plan pays is listed on your Schedule of Benefits.

Medical emergency means the sudden, unexpected, worsening or onset of a condition that threatens the patient's life or significant worsening of the underlying condition if medical attention is not received. Emergencies include, but are not limited to the following: heart attacks, strokes, loss of consciousness, convulsion, increasing or sudden fractures, strains, sprains, cuts, eye injuries, head injuries, swallowing of poisons, medication overdose, allergic reactions caused by insect stings or bites, burns, smoke inhalation, heat prostration and frostbite.

In general, routine care for minor medical problems treated in an emergency room are not covered by the Plan.

Ambulance Service

The Plan pays eligible expenses 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 neccessity. 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.

These services are considerred eligible when transport is medically necessary because transport by any other means would endanger the patient's health or the injury(ies) require(s) immediate first aid to stabilize the patient 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 the patient's condition requires transportation by air rather than ground or water ambulance;
- the patient is 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.

Maternity Care

The Plan pays eligible hospital room and board charges and other hospital services for pregnancy, childbirth or miscarriage for you or your eligible spouse. The amount that the Plan pays is listed on your Schedule of Benefits.

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).

Midwife Benefit

The Plan covers certain services for pregnancy, childbirth and miscarriage provided by a Certified Nurse Midwife (CNM). All fifty states certify CNMs, with most having a Masters Degree level in training. The Plan does not cover services provided by a Direct-Entry Midwife. Not all states license these practitioners. The Welfare Fund will not allow benefits for both a CNM and a physician, unless there are complications that require the intervention of a physician.

Skilled Nursing Facility Care

The Plan pays the eligible expenses for room and board and other medical services if you or an eligible dependent are transferred to a skilled nursing care facility immediately following a hospital stay. The amount that the Plan pays is listed on your Schedule of Benefits. Your provider must obtain prior authorization for skilled nursing facility care. Benefits are limited to a maximum of 730 days reduced by two times the number of days spent in the hospital for the same condition.

For example, if you are hospitalized for 30 days and then transferred to a skilled nursing care facility, you will be eligible for 670 days of coverage (two times 30 equals 60 and 730 minus 60 equals 670).

Remember: All Skilled Nursing Facility requires prior authorization by callling (800) 482-4040.

Home Health Care

Receiving care in your home is often more desirable than remaining in the hospital. The Plan pays the full cost of Home Health Care Services when ordered by a physician and prescribed under a home health care treatment plan *in lieu of hospitalization.*

Home Health Care in lieu of hospitalization requires prior authorization from the Welfare Fund Office.

In certain circumstances, home health care services are required which are not in lieu of hospitalization. Benefits for these services are paid under the Major Medical portion of your Plan. For further information on this benefit see page 21.

Hospice Care

Hospice care is designed specifically to treat the terminally ill and concentrates on pain management and professional counseling for both patients and their families.

Hospice care is generally provided in the home, although inpatient care is also available.

The Plan pays for eligible Hospice care expenses, provided that you have received prior authorization from the Welfare Fund Office. Benefits are paid as specified in your Schedule of Benefits.

Remember: All Home Health Care and Hospice Care require prior authorization by the Welfare Fund at (313) 964-2400, ext. 428, 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.

EXTENDED HOSPITAL/MEDICAL/SURGICAL BENEFITS

If you or your eligible dependent is confined to a hospital or has surgery after your coverage has ended, benefits *may* be extended to cover expenses for the treatment of the illness or disability.

To qualify for extended benefits, ALL of the following requirements must be met:

- the hospital confinement must begin or the surgery must be performed within three months after your coverage ended; and
- the person being treated must be totally disabled, as determined by the Plan Trustees, when coverage ended and remain continuously disabled until the date of hospital confinement or the date the surgery is performed; and
- the hospital confinement or surgery must result from the same injury or illness that caused the continuous total disability; and
- the hospital confinement or surgery must be an eligible expense.

MEDICAL/SURGICAL BENEFITS

You and your eligible dependents are provided with medical and surgical benefits that are paid according to the In-Network or Out-of-Network provider you have selected. The details of your coverage are provided in the Schedule of Benefits in the pocket at the end of the booklet. You should refer to your Schedule of Benefits as you read about your Medical/Surgical Benefits.

ELIGIBLE EXPENSES

Eligible expenses are those charges for medical services that you are legally required to pay. In certain instances, eligible expenses are limited to specified dollar maximums or specific scheduled amounts. These limits are shown in the Schedule of Benefits and in the discussion of each type of benefit in this Summary Plan Description.

ABOUT REASONABLE AND CUSTOMARY

The Reasonable and Customary charge is the portion of the medical care provider's charge that is covered by the Plan. The Trustees determine Reasonable and Customary charges based on the type of service provided and the fees that are charged for the same or similar services by other medical care providers in the area.

For example, if the Reasonable and Customary charge for a service is $100 and your doctor charges $120, the Plan will pay benefits based on $100 – the Reasonable and Customary Charge. If your Out-of-Network Provider does not accept the Reasonable and Customary charge payment in full, you will be responsible for any balance billed over that amount, plus any applicable copayments and deductibles.

SECOND AND THIRD MEDICAL OPINIONS

The Plan will pay for a doctor's Reasonable and Customary charge for a second opinion regarding a previously recommended medical treatment or surgical procedure, even if you choose not to follow the doctor's advice.

If you would like a third medical opinion, the Plan will pay the Reasonable and Customary charges for the third opinion.

Diagnostic lab tests and x-rays required as part of a second or third opinion are paid up to the Reasonable and Customary charge.

No deductible or copayment is applicable to doctors' charges for second and third medical opinions. 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.

SURGICAL EXPENSES

If you or your eligible dependent require surgery for an injury or illness that is not job related or the result of an auto accident, your benefits are based on the In-Network or Out-of-Network provider you have selected. Refer to your Schedule of Benefits.

BREAST RECONSTRUCTION

If you or an eligible dependent have a mastectomy, the Plan will pay 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; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

MATERNITY CARE

You or your eligible spouse are covered for certain pre-natal and post-natal care and obstetrical expenses related to maternity care.

Pre-natal and Post-natal care, including the cost of doctor's office visits or routine care provided by specialty physicians, is covered according to the In-Network or Out-of-Network provider you have selected.

Obstetrical procedures are covered based on the In-Network or Out-of-Network provider you have selected.

See Maternity Care on page 15 for additional information about outpatient and special inpatient services regarding maternity care.

MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE TREATMENT

Benefits are determined by the In-Network or Out-of-Network provider you have selected. The amount that the Plan pays and the limitations on benefits are listed on your Schedule of Benefits.

Remember: All inpatient and outpatient treatment for nervous and mental disorders and substance abuse requires prior authorization that can be requested by calling (800) 457-8540.

CHIROPRACTIC CARE

The Plan pays the eligible expenses for chiropractic care, including x-rays, up to the maximum dollar amount per person per calendar year that is listed in your Schedule of Benefits.

DOCTOR VISITS

Benefits for physician's office visits and in-hospital physician visits are covered based on the In-Network or Out-of-Network provider you have selected. You should refer to your Schedule of Benefits to determine how this benefit is paid.

OUTPATIENT X-RAY EXPENSES

X-ray services for you and your eligible dependents performed on an outpatient basis for non-occupational, non-auto-related illnesses or accidents are paid based on the In-Network or Out-of-Network provider you have selected. You should refer to your Schedule of Benefits to determine how this benefit is paid.

LABORATORY TEST BENEFIT

Most laboratory test charges for you and your eligible dependents performed on an outpatient basis for non-occupational, non-auto-related illnesses or accidents are paid based on the In-Network or Out-of-Network provider you have selected. You should refer to your Schedule of Benefits to determine how this benefit is paid.

HEARING AID BENEFITS

The Plan pays a scheduled amount for hearing aids, a hearing evaluation and testing once every two years if you and your eligible dependents suffer a hearing loss. You should refer to your Schedule of Benefits to determine how this benefit is paid.

Covered Hearing Aid Items

Hearing aids that are covered by the Plan include:

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

Hearing Aid Items Not Covered

The Plan does not cover the following items related to hearing aids:

- batteries;
- extended warranties;
- fitting;
- evaluations when billed in addition to a hearing aid; and
- early replacement due to loss or damage.

WELLNESS BENEFIT

The Plan will pay for eligible expenses related to periodic health examinations for you and your eligible dependents. Applicable copayments and deductibles will be waived for these services.

Types of Covered Examinations

For women, the Plan will pay according to your Schedule of Benefits for the following:

- Mammography screening.
- Cervical cancer screening (Pap smear).
- Periodic physical examination including family and personal history, health habits, height/weight, blood pressure, blood sugars (diabetes screening), cholesterol, triglycerides (lipid panel), skin cancer screens, breast cancer screens and pelvic examination.
- Stool occult blood tests.
- Flexible sigmoidoscopy screening.

For men, the Plan will pay according to your Schedule of Benefits for the following:

- PSA tests.
- Stool occult blood tests.
- Periodic men's physical examination including family and personal history, health habits, height/weight, blood pressure, blood sugars (diabetes screening), cholesterol, triglycerides (lipid panel), skin cancer screens, testicular cancer screening and digital rectal examination.
- Flexible sigmoidoscopy screening.

For children, the Plan will pay according to your Schedule of Benefits for the following in accordance with the recommendations of the American Academy of Pediatrics:

- Well baby and child physical examinations.
- Immunizations.

MAJOR MEDICAL BENEFITS

Major Medical benefits provide you and your eligible dependents with added protection against catastrophic medical expenses. Your Major Medical benefits will be determined by the In-Network or Out-of-Network provider you select.

DEDUCTIBLE

The deductible is the amount of eligible expenses you pay before the Plan begins paying. You pay an annual calendar year deductible. The "calendar year" is January 1 through December 31. The annual calendar year deductible is determined by the In-Network or Out-of-Network provider you select and is shown in your Schedule of Benefits.

Note: If you incur eligible expenses in October, November or December which apply toward your annual deductible, those expenses will also be applied toward the following year's deductible. Refer to your Schedule of Benefits to determine if your Plan has this provision.

COPAYMENT

The copayment is the percentage you pay after you satisfy the annual deductible. After you have satisfied the annual deductible, the Plan will pay a portion of eligible expenses and so will you. How much the Plan pays depends on the service provided and the In-Network or Out-of-Network provider you have selected. See the Schedule of Benefits for more information.

MAXIMUM BENEFIT

The Major Medical benefit has a lifetime maximum per individual and may have an annual maximum per individual. However, up to $5,000 of the lifetime maximum will be restored each January 1. You should refer to your Schedule of Benefits for these maximums.

BENEFITS PROVIDED BY THE PLAN

The Major Medical benefit covers expenses that:

- are not covered by other portions of the Plan; and
- exceed the amount of the annual deductible (subject to the Reasonable and Customary charge limits); and
- are needed for the diagnosis and treatment of a medical condition or injury; and
- are not job- or auto-related.

The following are examples of services covered under your Major Medical benefits:

- **Home Health Care.** Receiving care in your home is often more desirable than remaining in the hospital. The Plan pays for home health care services for you or an eligible dependent if recommended by a physician and prescribed under a home health care treatment plan. Home health care services are covered as long as this care is provided instead of hospitalization and is authorized before services are received.

Remember:: All home health care services require prior authorization by the Welfare Fund. You may request prior authorization by calling ext. 428 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.

- **Nursing Care.** The 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 prior Welfare Fund approval.

  Services of home health care nurses are limited as follows:

  > RN/LPN: Daily home health care visits are limited to the number of visits approved by the Welfare Fund as necessary for a particular course of treatment.

  > LPN: 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
  Up to 8 hours of care per day for 900 days lifetime maximum

  The Plan pays benefits for home health care services based on your network option, as shown in your Schedule of Benefits.

- **Durable Medical Equipment:** Equipment rental (or purchase, if approved in advance by the Welfare Fund) is also available under the Plan. Equipment includes wheelchairs, hospital beds, oxygen tents and other items required for the care of the patient in the home. Wheelchair replacement is limited to one chair every two years. The replacement must be needed because of a change in the person's medical status or growth.

Remember: The purchase of durable medical equipment requires prior authorization by the Welfare Fund. You must request prior authorization by writing to the Welfare Fund Office or calling (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.

- **Injections.**
- **Immunizations for dependent children.**
- **Hyperalimentation (TPN).**
- **Chemotherapy and radiation therapy.**
- **Dentists' or dental surgeons' expenses f**or repair of the jaw and natural teeth as the direct result of an accident (excluding work- or auto-related injuries).
- **Prescription drugs (IV therapy)** administered by an RN or LPN, provided drugs are not provided through the prescription drug program.

MAJOR MEDICAL BENEFIT EXTENSION

If you or your dependent undergo any treatment or receive any service specified in this booklet after your coverage ends, your Major Medical Expense Benefits will be extended provided ALL the following conditions are satisfied:

- the treatment or services are received within two years after your coverage ended; and
- you or your dependent must be totally disabled, as determined by the Plan Trustees, when coverage ended and remain continuously disabled until the date of such treatment or service; and
- the treatment or services must result from the same injury or sickness that existed on the date your coverage ended and caused this continuous total disability; and
- treatment or services must be eligible expenses.

In no event will benefits under this provision exceed the maximum hospital or medical benefits specified in your Schedule of Benefits.

Your eligible expenses under this provision are reimbursed at the percentage of the Reasonable and Customary amount that is listed in your Schedule of Benefits (or the scheduled amount, if applicable). Benefits provided under the Major Medical Benefit Extension do not qualify for payment under the In-Network option, but are paid at the Out-of-Network benefit level listed in your Schedule of Benefits. Your reimbursement is subject to any applicable annual deductible or copayment amounts listed in your Schedule of Benefits.

ADDITIONAL SERVICES AND SUPPLIES BENEFITS

The Plan will pay a percentage of the scheduled amounts, up to a lifetime maximum per person, for certain services and supplies that are not covered under the Major Medical benefit. See your Schedule of Benefits for the amount that the Plan pays and any limitations on benefits.

If you incur eligible expenses during the year, the amount is deducted from your overall lifetime maximum benefit. But on January 1 of each year, up to $1,000 of those expenses used the previous year will be added back to the lifetime maximum. Examples of expenses covered under this benefit include:

- **Physical, Occupational and Speech Therapy** is covered when you or an eligible dependent require physical, speech or occupational therapy to "restore" normal function lost due to accident or illness (i.e., stroke) that is not job related or the result of an auto accident.

Note: Developmental physical, speech or occupational therapy is not a covered expense. Physical, speech or occupational therapy to *maintain* function is not a covered expense. Normally, therapy for congenital-type diagnoses is required to develop or maintain function and is not payable under the Plan.

- **Prosthetic Devices** are covered when required for an illness or injury that is not job related or the result of an auto accident. Prosthetic devices are limited to once per lifetime unless replacement is required due to pathological change or up to once per year if a change is required due to growth.
- **Orthotics Benefit Coverage.** Orthotics are custom molded in-shoe rigid devices made from a plaster impression of the patient's foot.

With prior authorization orthotics coverage will be provided for the following diagnoses:

> flat feet (pes planus) and associated tendinous disorders (anterior and posterior tibial tendonitis);

> plantar fasciitis and other related diagnoses such as calcaneal tendonitis and heel spurs;

> second metatarsal displacement; and

> uneven limb length.

Authorization will be based upon effectiveness and standard of care for current quality podiatric therapy.

Prior authorization must be requested for orthotic devices by writing to or calling 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.

- **Dietary Counseling Benefit**. Unlimited Dietary Counseling by a Certified Dietician is a covered benefit for eligible active participants and pre-Medicare retirees, subject to applicable benefit plan copayments and/or deductibles, for certain diagnostic categories. To obtain a list of covered categories contact the Welfare Fund Office.
- **Services and supplies in the administration of hyperalimentation** are covered when approved in advance by the Welfare Fund as part of a home health care treatment program.
- **Supplies for administration of chemotherapy at home.** Chemical reagents used in chemotherapy are covered under the Major Medical Benefit.
- **Syringes**. Syringes necessary for the administration of insulin are covered.
- **Other medical supplies.** Other medical supplies are covered such as: ostomy bags and glucose strips. Medical supplies do not include electrodes for TENS units (Transcutaneous Electrical Nerve Stimulator), gauze, creams, lotions, tape, gloves or similar supplies that may be purchased without a prescription. The Welfare Fund covers supplies for use with wound care such as gloves, gauze and tape as part of a home health care treatment program.
- **Durable Medical Equipment.** The following durable medical equipment is covered:
  > TENS units (Transcutaneous Electrical Nerve Stimulator) for relief of pain.
  > EBIs (Electronic bone growth stimulators).
  > Slings and/or hoists deemed to be medically necessary for treatment of a disease or illness when approved in advance by the Welfare Fund.
- **Respite care.** Respite care services are covered up to a maximum of 24 hours per day for no more than seven days, when approved in advance by the Welfare Fund.

TEMPOROMANDIBILAR JOINT (TMJ) DYSFUNCTION.

The Plan will pay for eligible expenses related to the diagnosis and medical treatment of temporomandibular joint dysfunction, including Reasonable and Customary charges for x-ray, laboratory tests and hospitalization up to the lifetime maximum per person that is listed on your Schedule of Benefits.

HUMAN ORGAN AND TISSUE TRANSPLANT BENEFIT

The Plan covers Reasonable and Customary charges related to certain organ transplant procedures. All organ transplants require prior authorization. Should you require a transplant, your doctor or hospital should contact the Human Organ Transplant Procedures Administrator at (800) 242-3504. You may also contact the Welfare Fund Office 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
Heart	$175,000	$25,000	$100,000
Heart/Lung	$200,000	$25,000	$100,000
Lung	$200,000	$25,000	$100,000
Liver	$150,000	$25,000	$100,000
Pancreas	$100,000	$25,000	$100,000
Kidney	$100,000	$25,000	$100,000
Cornea	$ 10,000	N/A	N/A
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
Partial Liver	$175,000	$25,000	$100,000
Lobar Lung	$200,000	$25,000	$100,000
Pancreas/Kidney	$125,000	$25,000	$100,000
Small Intestine	$250,000	$25,000	$100,000
Small Intestine/Liver	$250,000	$25,000	$100,000

COVERED EXPENSES

The Welfare Fund provides coverage for five phases of transplant services as follows:

Phase I – Pre-Transplant Evaluation. This phase includes health services that are required to evaluate you for acceptance into a transplant program, subject to any limitations that are contained in this Plan. Health services include 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 includes health services provided following your acceptance into a transplant program and before the approved transplant takes place, subject to any limitations contained in this Plan. Health services include:

- 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 includes those health services required during the approved transplant through your discharge from the hospital, subject to any limitations contained in this Plan. Health services include:

- 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.

Additional approved transplants that you may require during Phases III or IV as a replacement of a previous transplant are considered as Phase III and IV health services. Phase III ends and Phase IV begins at the time you are discharged from the hospital to begin post-procedure global period care.

Phase IV – Post-Procedure Global Period. This phase includes 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 this 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 immunosuppressive 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 as Phase III and IV health services.

Phase V – Post Phase IV Health Services. This phase includes 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 this 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 benefits. Transplant benefits will continue until the maximum transplant benefits are exhausted.

EXPENSES NOT COVERED

The following items **are not covered** by the Plan:

- massage therapy, acupuncture or radial keratotomy;
- eye glasses, contact lenses, routine eye examinations, eye refractions and the fitting of eye glasses;
- 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;
- pregnancy expenses for other than a participant or covered spouse;
- any treatment or service not provided or ordered by a physician;
- expenses that exceed specified benefit levels listed in your Schedule of Benefits for the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ);
- any medical, surgical or psychotherapy expenses related to sex change operations;
- expenses for the treatment of nervous or mental disorders or substance abuse that exceed specified benefit levels;
- any expenses incurred that exceed the Major Medical per person lifetime limit;
- charges for care, treatment, services and supplies that are considered experimental or investigational in nature and/or not considered reasonable and customary by any government agency or subdivision (including the HCFA Medicare Coverage Issues Manual);
- expenses that are not covered expenses;
- charges that exceed the Reasonable and Customary charge or scheduled amount or limit;
- any treatment, except dietary counseling, maternity and wellness care that is not the result of a sickness, illness or injury (e.g., obesity, sterility, impotency, developmental disorders, pain control, etc.);
- benefits for eligible dependents in a Health Maintenance Organization (HMO) that were denied because the HMO guidelines were not followed;
- expenses for transportation, other than medically necessary use of an ambulance;
- expenses for custodial, convalescent or rest-cure-type 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 (however, these may be covered under your prescription drug program);
- weight loss programs, except dietary counseling;
- any charges for the purchase of durable medical equipment except when prior authorized by the Welfare Fund;
- 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;
- charges above the scheduled amount for anesthesia, authorized durable medical equipment, prosthetics, nursing visits, orthotics, physical therapy, speech therapy and occupational therapy;
- developmental speech, occupational and physical therapy; and
- any expenses shown in Exclusions and Limitations on page 45.

PRESCRIPTION DRUG BENEFIT

The Welfare Fund provides you and your dependents with prescription drug coverage. Your Plan provides two methods of receiving prescription drugs:

- a prescription drug card program; and
- a Mail Service Maintenance Prescription Drug Program.

PRESCRIPTION DRUG CARD PROGRAM: BCBSM

The Plan will cover the cost of most prescription drugs after you pay the copayment amount shown in your Schedule of Benefits for each separate prescription drug order and each refill. Blue Cross Blue Shield of Michigan (BCBSM) administers the prescription drug program.

When you or an eligible dependent need to purchase prescription drugs, you may go to any pharmacy in Michigan that has an agreement with BCBSM. If you purchase prescription drugs at any pharmacy outside the state of Michigan, the Plan will pay 100% of the amount approved by Blue Cross Blue Shield of Michigan after you pay the copayment.

If there is a generic equivalent to a brand name drug, the Plan will pay only for the generic drug, unless the prescription order indicates "Dispense as Written (DAW)." If the prescription does not say "Dispense as Written" but you request a brand name, you will be responsible for the copayment plus any amount related to the difference in cost between the generic drug and the brand name drug. This does not apply to prescriptions filled outside of Michigan.

Filling a Prescription at a Pharmacy

To get a prescription filled, take your written prescription to an authorized pharmacy. Present your prescription drug card to the pharmacy along with the copayment.

You may obtain up to a 34-day supply of prescription drugs through this program.

MAIL SERVICE MAINTENANCE PRESCRIPTION DRUG PROGRAM

You and your eligible dependents can also obtain a 90-day supply of maintenance or long-term medication for chronic conditions through the Mail Service Maintenance Prescription Drug Program. This program offers low cost, convenient mail service for long-term prescription needs.

Maintenance medications are usually drugs that are prescribed on an ongoing basis for treatment of illnesses such as anemia, diabetes, high blood pressure, heart disorders, arthritis and other chronic conditions.

You and your eligible dependents can save money by having your maintenance drugs and refills prescribed for a 90-day supply. Normally, local pharmacies dispense a 34-day supply and you pay a copayment. Under this program, you only have to make one copayment for a 90-day supply instead of three separate copayments.

In addition to the cost savings, this program provides the convenience of home delivery by first class mail or UPS. The program pays all necessary postage.

Filling a Prescription Through the Mail Service

If you or an eligible dependent have a chronic condition that requires ongoing maintenance medication, have your physician write a prescription for at least a 90-day supply of medication. Obtain a patient profile form from the Welfare Fund Office for your first order. Fill out the form and mail it, along with the original prescription and the copayment for each prescription. The Mail Service Maintenance Prescription Drug Program will process your order and return your medication to you within 14 days along with re-order instructions for future prescriptions or refills.

Prescriptions are monitored and checked to ensure safety and accuracy. Each prescription is checked by the Mail Service Maintenance Prescription Drug Program's computerized system designed to check drug interactions between drugs prescribed by physicians that you have identified in your patient profile form. Each prescription is also screened by at least three registered pharmacists. If any questions or problems arise concerning the prescription, the pharmacist will contact your physician directly.

If you have any questions about your medications, you can contact the customer service department toll-free at (800) 243-9800. Licensed pharmacists are available to answer your questions.

EXPENSES NOT COVERED

The Prescription Drug Program does not cover the following items:

- charges for any take-home drugs (for example: drugs brought home after out-patient surgery);
- charges for contraceptive medicine or devices, even if such medication or device is a prescription Legend Drug;
- 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, diet supplements and vitamins (other than pre-natal vitamins);
- 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 the physician or dentist, or any refill dispensed after one year from the date of the original prescription;
- the charge for any medication you or your dependent 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; and
- any expenses shown in Exclusions and Limitations on page 45.

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 33 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 flp-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	Alveoloplasty 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 55 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.

WEEKLY ACCIDENT & SICKNESS BENEFITS

The Plan provides weekly benefits if you are disabled due to a non-occupational or non-auto-related illness or injury while you are actively employed. Benefits are payable only if you are incurring a loss of income as a result of your illness or injury.

HOW THE PLAN PAYS BENEFITS

Benefits will begin:

- 30 days following medical attention after the last day worked in the event of an accident; or
- if you choose to use your "banked" sick time, 30 days following the date your banked sick time is depleted.

You will receive the amount shown in your Schedule of Benefits each week for up to a maximum of 39 weeks for each period of disability. You will receive this benefit provided you are:

- unable to perform the duties of your job; and
- under the regular care of a licensed physician who confirms your disability.

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

CONTINUATION OF BENEFIT ELIGIBILITY

While you are collecting your Weekly Accident & Sickness Benefits, you and your eligible dependents will remain eligible for all other Plan benefits you and they would otherwise be entitled to receive.

WHAT IS DISABILITY?

Under the Weekly Accident & Sickness Benefits, disability means your inability to perform the regular duties of your employment because of a non-occupational or non-auto-related accident, sickness or pregnancy. You may not engage in any gainful occupation during any period of disability.

Two or more periods of disability are considered one period of disability unless:

- you return to active full-time work for at least 14 calendar days between disabilities; or
- the disabilities are due to unrelated causes and begin after you return to active full-time work for at least one day.

HOW BENEFITS ARE TAXED

Your Weekly Accident & Sickness Benefits are subject to withholding for federal FICA (Social Security) tax purposes.

NOT COVERED

Weekly Accident & Sickness Benefits are not payable for:

- Any disability that is the result of a job-related illness or injury or that can be compensated through workers' compensation or any occupational disease law.
- Any disability that is the result of an injury or illness caused by war or any act of war, declared or undeclared; or during military service for any country at war.
- Any injury or illness that is a direct or indirect result of an automobile accident, injury or illness as defined under Michigan's "No-Fault" automobile insurance provisions, whether the vehicle is actually insured or not.
- Any injury or illness that is a direct or indirect result of an automobile accident, injury or illness that occurs to a Plan participant residing outside Michigan if the resulting expenses are required to be paid under state law (except for death benefits).
- Any injury or illness that is a direct or indirect result of an automobile accident, injury or illness that occurs to Plan participants as the operator or occupant of a rental car where there is other coverage (except for death benefits).
- Any disability that occurs during a period of time you would not otherwise be working if the disability had not occurred; for example, if a disability occurs while you are laid off.

BLUE HEALTHLINE – 24-HOUR HEALTH INFORMATION

Blue HealthLine is a program that gives you 24-hour a day telephone access to registered nurses. You may call the toll free numbers – (800) 811-1764 or TTY (800) 240-3050 for the hearing impaired – if you have common health questions. If you press ∗ you will be connected to a registered nurse. During your telephone conversation, the nurse can help you:

- assess an illness or injury;
- find ways to live a healthier life;
- understand a treatment plan prescribed by your doctor;
- learn how to control a chronic condition (like diabetes or high blood pressure); and
- take an active role in your medical care.

Blue HealthLine also gives you access to an up-to-date audio health library with more than 1,600 pre-recorded health messages on tape. You can choose a particular health-related topic and listen to the information from your telephone. Additional details about this program and the health library are available in the Blue HealthLine booklet available from the Welfare Fund Office.

***Important Note*:** Blue HealthLine is **not** a 911 emergency line. If you have an emergency situation or illness or injury that requires immediate attention, you will be directed to go to the emergency room or call your local 911 number for assistance.

EXCLUSIONS AND LIMITATIONS

The following are not covered under this Plan:

- injury or sickness arising in the course of employment or which is covered under any workers' compensation or occupational disease law or other state law or other insurance;
- expenses incurred for care of injuries or sickness due to war or war-related acts;
- any expenses you or your eligible dependents incur that you or your eligible dependents 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 to participants and their dependents who are covered by Michigan "No-Fault" automobile insurance and suffer an injury or illness in an out-of-state automobile-related
  accident, NO medical benefits will be paid by the Plan for auto-related injuries or illnesses;
- Plan participants and their eligible dependents residing outside the State of Michigan who suffer an injury or illness resulting from an automobile accident out-of-state will NOT be eligible for any medical benefits under any Welfare Fund Plan, if such benefits are payable or required to be covered under other insurance or applicable state law;
- in such cases where other medical coverage is available, NO Plan benefits will be paid for automobile-related injury or illness on behalf of a participant or dependent who is 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 the participant is legally required to pay;
- charges for completing claim forms;
- claims made for benefits beyond one year from the date the expense was incurred; and
- loss suffered while in the armed forces of the United States.

HOW TO FILE A CLAIM

Claim forms are available from the Welfare Fund Office. Submit claim forms to the Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, Michigan 48216. You may call Member Services at (313) 964-2400 to check on the status of your claim, 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. If you use In-Network providers, they will generally file claims for you.

CLAIMS FOR MEDICAL BENEFITS

If you use an In-Network provider, the provider will generally submit your claim. If you use an Out-of-Network provider, to ensure prompt processing of your claim, you must complete all sections of the claim form including other insurance information and accident information, if appropriate. The attending physician must complete his/her section including diagnosis, dates of service, procedure codes and itemization of charges (or your provider may submit a completed HCFA 1500 Form for services rendered).

Generally, it is not necessary to submit a claim for inpatient hospital or outpatient hospital expenses. These will be filed by the hospital directly with BCBSM. You should present your Blue Cross Blue Shield of Michigan card for inpatient or outpatient services performed at a hospital and for ambulance services. See page 13 for more information about using your Blue Cross
Blue Shield card.

CLAIMS FOR WEEKLY ACCIDENT & SICKNESS BENEFITS

You must submit a claim form to the Welfare Fund Office for Weekly Accident & Sickness Benefits. You must complete the section of the form entitled "Claimant's Statement." Your doctor must complete the "Attending Physician's Statement" portion of the form and your employer must complete the section called "Employer's or Terminal Manager's Statement."

Each time you receive a benefit check, you also will receive a form called "Report of Continued Disability." You, your doctor and your employer must complete each form and submit it to the Welfare Fund Office to verify your continuing eligibility and ensure that you continue receiving benefit payments.

FILING DEADLINE

All claims for benefits must be FILED WITHIN ONE YEAR after the date of loss or the date the eligible expense is incurred or for accident and sickness claims, within one year after the accident or sickness occurs. 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.

PAYMENT OF CLAIMS

Benefits for covered health care services that you are legally required to pay are normally paid directly to the providers of health care, up to the Reasonable and Customary charges, provided these expenses have not yet been paid by you. However, the Trustees may pay benefits to the following:

- you;
- your spouse, if benefits are payable as a result of health care services to the spouse;
- your dependent child or his or her legal guardian who actually paid the expenses, if benefits are payable as a result of health care provided to your dependent child;
- any person related to you by blood or marriage whom the Trustees believe to be equitably entitled to benefits;
- your estate, if benefits are payable for health care services incurred before your death or disappearance; or
- an insurance company or other third party.

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

You would receive $75 in benefits from the *primary plan* and an additional $15 in benefits from this Plan. The $15 is the difference between what the other plan covers and what this Plan pays ($90 less $75 equals $15) after deductibles and copayments.

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 is not considered in determining the benefits payable under this 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 this Plan.

COORDINATION WITH MEDICARE

Medicare provides insurance to people who:

- are age 65 and older;
- are disabled; or
- have permanent kidney failure.

Medicare has three parts. "Part A" provides benefits for hospital expenses, skilled nursing facilities, home health services and hospice care. "Part B" provides benefits for physicians services and other medical and health services. "Part C" (Medicare + Choice) provides options on how Medicare coverage will be provided.

If you are age 65 or over and entitled to Social Security benefits, you will be entitled to "Part A," whether or not you are retired. You will have to file an application with the Social Security Administration at least three months before you reach age 65.

Coverage under Part B is voluntary. It is designed to supplement the limited coverage provided by Part A. Part B is available at age 65 or older. If you enroll in Part B, you will have to pay monthly premiums.

For more information about Medicare benefits, contact your local Social Security Administration office. To receive enrollment materials, call (800) 772-1213.

Active Participant/Dependent Age 65 or Older

If you are an **active** participant 65 years of age or older, or a Medicare-eligible dependent of an **active** employee, the Welfare Fund provides primary coverage and Medicare provides *secondary* coverage. In other words, when you have an eligible expense, the Welfare Fund will pay benefits first and any remaining expenses not covered by the Welfare Fund will be paid by Medicare. This applies only if Medicare would normally cover that particular expense.

If an expense is covered by Medicare, this Plan generally considers it an eligible expense. When coordinating Plan benefits with Medicare, the following are **not** eligible expenses under this Plan.

- Charges in excess of Medicare assignments. If your doctor accepts the Medicare assignment, he or she accepts Medicare's approved amount as the total eligible charge for the assigned services.
- Charges in excess of Medicare's participating physician reimbursement limits. If your doctor is a participating Medicare physician and does not accept Medicare assignment, you are not obligated to pay charges in excess of Medicare's physician reimbursement limits.
- Charges made by a non-qualified Medicare provider, including a non-participating physician, supplier or facility. When you are in need of medical services, it is important to ask whether services are going to be provided by an approved Medicare provider and at an approved Medicare facility.

If you are eligible for Medicare, these coordination of benefit rules are applied as if you are eligible for both Part A and Part B coverages under Medicare, even if you do not elect Part B coverage. Therefore, it is important for you to maintain both Part A and Part B coverage under Medicare to reduce your costs because the Plan will coordinate benefits as though Medicare had paid the percentage that would be paid if you elected Medicare Part B coverage. If you elect Medicare Part C coverage, the coordination of benefits rules will be applied.

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 ADMINISTRATIVE 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 weekly accident and sickness, medical, dental, optical expense and prescription drug 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 the applicant is entitled to them.

IMPORTANT DEFINITIONS

The following are definitions of specific words and terms used in this Summary Plan Description.

Brand name drug means a prescription drug that is or was protected by patent.

Collective Bargaining Agreement means the negotiated labor agreement between the Michigan Conference of Teamsters or any of its constituent Local Unions and your employer that requires contributions to the Welfare Fund.

Copayment or copay means the amount you are responsible for paying when you incur certain medical services or obtain prescription drugs.

Contributions mean payments made to the Welfare Fund by an employee or contributing employers on behalf of an employee.

Covered under the Plan means a person is eligible to receive Plan benefits that apply to the person's status as an employee or dependent of an employee.

Deductible means the amount of eligible expenses you pay before the Plan begins paying.

Dependent means a person who is:

- your spouse while you are married and not divorced.
- your unmarried child by birth or adoption, or 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 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 or adoption whom you claimed as a dependent on your most recent federal income tax return, regardless of his or her age, who has been determined by a licensed physician, psychologist or psychiatrist to be permanently and totally disabled by
  a disability that began while the individual 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.

Doctor or physician means a doctor or surgeon 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 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.

Eligible individual means an employee or dependent who is eligible for benefits under the Plan.

Emergency treatment center means a facility, regardless of what it is called, used primarily to provide minor emergency and medical care. The facility must be staffed with a doctor, nurse and registered x-ray technician during hours of service and it must have x-ray and laboratory equipment and a life support system.

Employee means a person who is working for a contributing employer under the terms of a collective bargaining agreement or whose employer makes contributions to the Welfare Fund under a participation agreement.

Employer, contributing employer or **participating** employer means any person, firm, association, partnership or corporation that enters into a collective bargaining agreement with the Union requiring contributions to the Welfare Fund or that makes contributions to the Welfare Fund under a 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 HCFA Medicare Coverage Issues Manual.

Generic drug means a prescription drug that has never been protected by patent or where the patent has expired.

Home health agency means a program of care from a public or private agency that:

- provides skilled nursing and therapeutic services at the residence of the patients;
- has professional policies governing its services;
- provides for supervision of its services by a physician or registered nurse;
- maintains clerical records of all patients;
- is properly licensed in the state and locality where it provides services; and
- is eligible to participate under Medicare.

Hospital means an institution that:

- is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- is a hospital or a psychiatric hospital as defined in Medicare that 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.

Legend drugs are any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution - Federal Law prohibits dispensing without a prescription."

Maintenance drug means a prescription drug taken for long periods of time to treat chronic conditions (such as diabetes or hypertension).

Master Plan Document means the documents that set forth all Plan terms and provisions. 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.

Medically necessary means those services, treatments or supplies provided to you or your dependents by a hospital or doctor, which services are required, in the judgment of the Trustees, to identify or treat an injury or sickness and:

- are consistent with the symptoms, diagnosis or treatment of the condition, disease, sickness or injury;
- are appropriate according to acceptable standards of good medical practice;
- are not solely for the convenience of the patient, doctor or hospital;
- are the most appropriate that can be safely provided to you under the circumstances; and
- are not experimental or investigative.

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 may later be amended.

Mental or nervous disorder means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or sickness of any kind, as identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Plan means the program of benefits described in this booklet and any other written documents that the Trustees designate to be part of the program of benefits under the terms of the Trust Agreement.

Prohibited Employment means (a) employment in any position by an employer that contributes to the Fund 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 the Fund.

Reasonable and Customary charges means the portion of the medical care provider's charge that is covered by the Plan. The Trustees determine Reasonable and Customary charges based on the type of service provided and the fees that are charged for the same or similar services by other medical care providers in the area.

Retirement means your termination of employment with an employer contributing to the Fund on your behalf for coverage under the Fund.

Retiree means a former employee of an employer that made contributions to the Welfare Fund under the terms of a collective bargaining agreement or under a participation agreement.

Schedule of Benefits means the document that describes how specific benefits are administered and that is part of this Summary Plan Description.

Seasonal Work means work that is performed only during temperate weather and that ceases during all or a substantial portion of the winter months due to low temperatures, snow or icy conditions.

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.

Summary Plan Description (SPD) means this booklet and the Schedule of Benefits that provide you with a simplified summary of the Plan Document. If any information in this summary or schedule is unclear or incorrect, the provisions of the Master Plan Document will govern.

Treatment facility for alcoholism and/or drug addiction means a rehabilitation facility for the treatment of persons suffering from alcoholism or drug addictions. The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and must be approved by the Trustees.

Trust Agreement means the documents, including all amendments, establishing the Welfare Fund and its rules of operation.

Trustees means the individuals appointed and designated according to the terms of the Trust Agreement to administer the Plan.

Union means the Michigan Conference of Teamsters and its affiliated Local Unions.

Welfare Fund means the Michigan Conference of Teamsters Welfare Fund.