

SUMMARY PLAN DESCRIPTION



Michigan Conference
of Teamsters Welfare Fund
Summary Plan Description

RETIREE PLAN

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).

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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
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(800) 457-8540	Prior authorization of treatment for Mental and Nervous Conditions and Substance Abuse
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(800) 242-3504	Prior authorization of Human Organ Transplant Procedures
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(800) 445-6417	Prior authorization of all other hospital admissions
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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 Retiree Plan in effect as of July 1, 2001. The Retiree Plan is a group health plan that provides two types of benefits: Retiree Medical coverage through the Retiree Medical Program and Post-65 Pharmacy coverage through the Affinity Rx Prescription Drug Program. This booklet describes both types of 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 Retiree 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 Retiree 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 Retiree 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 FOR RETIREE PLAN BENEFITS

RETIREE MEDICAL PROGRAM ELIGIBILITY

To be eligible for coverage under the Retiree Medical program, you must:

- be a Retiree (see Definitions) and be at least age 57 and
 - > have had contributions under the Welfare Fund Plan that provided retiree coverage (either by an employer or self-contributions at the applicable COBRA rate) made on your behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately before retirement or at least 40 weeks in seven out of the ten consecutive 52-week periods immediately before retirement; except that
 - > for periods while you performed *seasonal work* (see Definitions), contributions under the Welfare Fund Plan that provided retiree coverage must have been made for an average of at least 40 weeks per 52-week period for five consecutive 52-week periods immediately before retirement, or, an average of at least 40 weeks per 52-week period for seven out of the ten consecutive 52-week periods immediately before retirement (the appropriate test will be applied pro rata based on the type of work in which you were engaged during the measuring period); or
- be at least age 50 and
 - > have had contributions under the Welfare Fund Plan that provided retiree coverage (either by an employer or self-contributions at the applicable COBRA rate) made on your behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately before retirement or at least 40 weeks in seven out of the ten consecutive 52-week periods immediately preceding retirement; except that
 - > for periods while you performed seasonal work (as defined under Definitions), contributions must have been made under the Welfare Fund Plan that provided retiree coverage for an average of at least 40 weeks per 52-week period for five consecutive 52-week periods immediately before retirement, or, an average of at least 40 weeks per 52-week period for seven out of the ten consecutive 52-week periods immediately before retirement (the appropriate test will be applied pro rata based on the type of work in which you were engaged during the measuring period); and
 - > have worked at least 20 years under collective bargaining agreements with affiliated local unions of the International Brotherhood of Teamsters.
- not be eligible for Medicare coverage;
- not be engaged in Prohibited Employment (see Definitions);
- elect to receive Retiree Benefit Coverage by filing with the Welfare Fund the Election Form within 90 days following the Retirement Date (see Definitions); and
- make self-contributions to the Welfare Fund in the amount established by the Trustees. The first self-contribution must be submitted to the Welfare Fund with the Election Form. Subsequent self-contributions must be received on or before the 20th day of the month preceding the month for which coverage is provided.

For example, if you want to be covered by the Plan in March, your contribution is due by February 20th. If you fail to pay your contributions on time, you and your spouse will not be eligible for any Retiree Plan benefits and you will permanently lose your eligibility for any coverage in the future.

RECOGNITION OF OTHER FUND PARTICIPATION – RECIPROCITY

If prior contributions were made on your behalf during the 26 or more weeks immediately before your retirement under the Central States, Southeast and Southwest Areas Health and Welfare Fund then you will receive credit for those contributions. This credit is used to determine whether you meet the contribution requirements for Retiree Plan coverage.

You may call the Welfare Fund Office Member Services Department at (313) 964-2400 to check on whether you are eligible for coverage under the Retiree Plan. You may also call Member Services toll free at (800) 572-7687 in the Metro-Detroit area, (800) 824-3158 in upstate Michigan or (800) 334-9738 outside of Michigan.

WHEN YOUR COVERAGE BEGINS

Generally, you are covered under the Retiree Plan when your eligibility has been confirmed and you have paid your self-contributions for coverage.

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

Retiree Medical Program coverage is available only for you and your spouse.

- If you are covered under the Retiree Medical Program, coverage automatically is provided to your wife or husband under age 65 and not eligible for Medicare.
- When you reach age 65, your spouse who is not yet age 65 and not eligible for Medicare may continue coverage under the Retiree Medical Program at the same contribution rate for five years following the date your Retiree Medical Program coverage began or until he or she attains age 65 or is eligible for Medicare.
- If you are covered under the Retiree Medical Program when you die, your surviving spouse who is not yet age 65 and not eligible for Medicare may continue coverage under the Retiree Medical Program at the same contribution rate for five years following the date your Retiree Medical Program coverage began or until she or he attains age 65, or is eligible for Medicare.

Upon your attainment of age 65 or your death, your spouse may continue coverage under the Retiree Medical Program after the five year period following the date your Retiree Medical Program coverage began, until he or she reaches age 65 or becomes eligible for Medicare, but only if your spouse pays an increased contribution rate determined by the Trustees.

DEFERRAL OF RETIREE MEDICAL PROGRAM COVERAGE

If you are a Retiree who has met all eligibility requirements but you have other medical coverage, you may waive electing Retiree Medical Program coverage upon approval of your written request to the Welfare Fund, submitted with documentation of your other coverage.

If you are a Retiree who qualifies for a 30 and Out Pension from a Teamster Pension Fund (see Definitions) and you have met all eligibility requirements with the exception of reaching age 50, you must defer Retiree Medical Program coverage until you reach age 50, by making a written request and submitting documentation of your 30 and Out Pension eligibility.

If you elect to defer Retiree Medical Program coverage, you must meet all of the requirements in effect when you later elect coverage and submit proof of termination of your other medical coverage. Coverage will begin upon receipt of the required monthly contribution.

In the event of your death, attainment of age 65 or eligibility for Medicare, the period of time that your participation was waived or deferred does not count toward the five years for determining continued eligibility for your spouse.

ENROLLING IN THE RETIREE PLAN

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

Completing this card in an accurate and timely manner is important. If the Welfare Fund receives a claim for you or your spouse and you have not completed the enrollment card, processing your claim and reimbursing your expenses will be delayed.

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 or change in your spouse’s employment or other coverage. If the Retiree 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.

TERMINATION OF RETIREE MEDICAL PROGRAM COVERAGE ELIGIBILITY

You and your eligible spouse may lose benefit coverage under the Retiree Plan if you or your spouse do not make the required contributions under the Retiree Plan within the timeframe permitted or if the Trustees of the Welfare Fund change, amend or terminate this Plan.

Your Retiree Medical Program coverage will end upon the first of the following dates:

- the date you reach age 65;
- the date you first become eligible for Medicare coverage, whether or not you enroll in Medicare coverage;
- the date of your death;
- the date you become eligible for coverage under a Welfare Fund Plan as an active employee;
- the date you engage in prohibited employment;
- the date the Welfare Fund fails to receive a monthly contribution when due; or
- the effective date of (1) termination of the Retiree Plan or Retiree Medical Program coverage as determined by the Trustees, or (2) an amendment to the Retiree Plan by the Trustees that makes you no longer eligible.
- If your Retiree Medical Program coverage ends as a result of your engagement in Prohibited Employment or failure to make a monthly contribution when due, you cannot re-elect this coverage at any time for any reason.
- Your failure to file an Election Form on time will result in your loss of eligibility; however, the Trustees may, in their discretion, permit a late filing if you demonstrate to the Trustees' satisfaction that your failure to file timely resulted from circumstances beyond your control. You must follow the claims and appeals process to submit your proof and to request permission for a late filing.

WHEN YOUR SPOUSE'S RETIREE MEDICAL PROGRAM COVERAGE ENDS

Your spouse's coverage under the Retiree Medical Program ends on the earliest of:

- the date your spouse reaches age 65;
- the date your spouse becomes eligible for Medicare coverage;
- the date you engage in prohibited employment;
- the date the Welfare Fund fails to receive a monthly contribution when due;
- the date of your spouse's death;
- the date you become eligible for coverage under a Welfare Fund Plan as an active employee; or
- the effective date of (1) termination of Retiree Plan or the Retiree Medical Program as determined by the Trustees, or (2) an amendment to the Retiree Plan by the Trustees that makes your spouse no longer eligible.

COBRA: CONTINUING YOUR BENEFITS

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

The continuation coverage will be identical to the Retiree Medical Program coverage available under the Retiree Plan. Your spouse will be required to pay the full cost for the continued coverage, plus an administrative charge. If your spouse remarries during a period of COBRA continuation coverage, the new spouse may be added to the coverage for the balance of the period of continuation coverage. There may be an additional cost for this added coverage. Your spouse's payments for COBRA continuation coverage must be made on time or coverage will be terminated.

Coverage Continues For 36 Months

Your eligible spouse may elect to continue Retiree Medical Program coverage under COBRA for up to 36 months if Retiree Medical Program coverage under the Retiree Plan ends for the following reasons or “qualifying events:”

- your eligibility for Medicare; or
- your death; or
- your divorce.

LOSS OF CONTINUED COVERAGE

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

- your spouse becomes covered under another group medical plan; however, coverage may be continued if your eligible spouse has a health problem for which coverage is excluded or limited under the other group medical plan;
- the required contributions are not paid on time;
- the Retiree Plan is terminated;
- your spouse reaches the end of the 36-month continued coverage period; or
- your spouse becomes entitled to Medicare.

NOTIFYING THE WELFARE FUND OFFICE

You or your spouse is responsible for notifying the Welfare Fund Office in case of divorce or death. This must be done within 60 days of the divorce or within 60 days from the date you receive the election form for continuing coverage, whichever is later.

Your spouse will be given an additional 45 days from the date continued coverage is elected to make any back payment necessary to avoid a gap in coverage. Payments for subsequent months are due the first day of the month for which coverage is provided.

To help ensure that coverage is not lost, we recommend that you or your spouse notify the Welfare Fund Office as soon as possible of any events that can cause your spouse's coverage to end. If the Retiree 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.

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 Retiree 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 your eligible spouse.

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 (313) 964-2400, ext. 375, 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 Retiree Plan does not have a preexisting condition exclusion.

MAJOR MEDICAL

Major Medical benefits provided under the Retiree Medical Program give you and your eligible spouse protection against certain catastrophic medical expenses.

“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.

Annual Deductible

The deductible is the amount of eligible expenses you pay before the Retiree 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 shown in the Schedule of Benefits.

Copayment

The copayment is the percentage you pay after you satisfy the annual deductible. After you have satisfied the annual deductible for the Retiree Medical Program, the Retiree Plan will pay a portion of eligible expenses and so will you. The Retiree Plan pays 80% of the first \$5,000 of eligible expenses per person after the deductible has been satisfied. You pay 20% of the first \$5,000 (\$1,000) per person. With a few exceptions noted under the individual descriptions of benefits, the Retiree Plan pays 100% of Reasonable and Customary charges over \$5,000 up to the calendar year maximum benefit.

Out-of-Pocket Limit

The Retiree Medical Program limits the amount of money that you will have to spend for deductibles and copayments during each calendar year. The “out-of-pocket limit” is based on your “network option.” See the Schedule of Benefits for your copayment and out-of-pocket limit.

Certain costs do not count toward your annual out-of-pocket limit, including:

- copayments for benefits paid at 50% by the Plan;
- a copayment required for office visits;
- copayments for chiropractic services paid by the Plan;
- your costs for services not covered by the Plan; and
- amounts you pay because the charge exceeds the Plan's Allowed Amounts or scheduled limit.

Benefit Maximum

The Major Medical benefit has a calendar year maximum per individual of \$150,000. Charges for hospital expenses and payments for all other eligible expenses are counted toward the calendar year maximum. See the Schedule of Benefits for the benefit maximum.

ELIGIBLE EXPENSES

Eligible expenses are those Reasonable and Customary 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 the Retiree Medical Program 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.

SCHEDULE OF BENEFITS

Additional information about the Retiree Medical Program, 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 28 for information about filing claims for medical benefits.

BENEFITS PROVIDED UNDER THE RETIREE MEDICAL PROGRAM

The Retiree Medical Program covers expenses that:

- 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, illness or injury; and
- are non-occupational or are not covered under the Michigan no-fault auto laws.

Services and supplies covered under the Retiree Medical Program and limitations on coverage are described in the following sections. Unless otherwise specified, the deductible, copayments and calendar year maximum described above and in your Schedule of Benefits apply to the following benefits.

YOUR HOSPITAL BENEFITS

The Retiree Medical Program 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.

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 Retiree Medical Program covers eligible expenses 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 pays the percentage of eligible expenses as described in the Schedule of Benefits *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 any work you may do while retired and 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 necessity. Transfer from one hospital facility to another and back, to receive treatment recommended by a doctor but not available at the facility of origin, is also covered.

These services are considered 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 your eligible spouse 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 calling (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.

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.

MEDICAL/SURGICAL BENEFITS

You and your eligible spouse are provided with medical and surgical benefits. 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.

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 applied to doctor's 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

The Retiree Medical Program covers expenses of surgery for an injury or illness that is not job related or the result of an auto accident. Refer to your Schedule of Benefits.

Breast Reconstruction

If you or your eligible spouse 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.

Mental and Nervous Disorders and Substance Abuse Treatment

The amount that the Plan pays and the limitations on benefits are listed on your Schedule of Benefits.

Your copayment for physician fees does not accumulate toward satisfaction of your calendar year out-of-pocket expense limit.

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. Your copayment does not accumulate toward satisfaction of your out-of-pocket expense limit.

Doctor Visits

Benefits for physician's office visits and in-hospital physician visits are covered.

Outpatient X-Ray and Laboratory Expenses

X-ray and laboratory services for you and your eligible spouse performed on an outpatient basis for non-occupational, non-auto-related illnesses or accidents are covered.

Wellness Benefit

The Plan will pay for eligible expenses related to periodic health examinations for you and your eligible spouse. 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.

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.

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, 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.

Temporomandibular 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.

CONTINUATION OF TRANSPLANT BENEFITS

If you were receiving transplant benefits under a Welfare Fund Plan for active employees and you retire during any of the transplant service phases, including the start of Phase I, your transplant benefits will continue if you are covered under the Retiree Medical Program. Transplant benefits will continue until the maximum has been exhausted.

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

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 per person calendar year 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 an eligible spouse 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;
- expenses for dependent children;
- developmental speech, occupational and physical therapy; and
- any expenses shown in General Exclusions and Limitations on page 27.

RETIREE MEDICAL PROGRAM PRESCRIPTION DRUG BENEFIT

The Retiree Medical Program provides you and your spouse with prescription drug coverage. Your Plan provides two methods of receiving prescription drugs:

- filling your prescription at a pharmacy; and
- filling your prescription through mail service.

FILLING YOUR PRESCRIPTION AT A PHARMACY

The Retiree Medical Program 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.

Using Your Prescription Drug Card

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.

FILLING YOUR PRESCRIPTION THROUGH MAIL SERVICE

You and your eligible spouse can also obtain a 90-day supply of maintenance or long-term medication for chronic conditions through the mail service. 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 spouse 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.

Using the Mail Service

If you or your eligible spouse 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 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'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 Retiree Medical Program's Prescription Drug coverage 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 spouse 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 General Exclusions and Limitations on page 27.

AFFINITY Rx PRESCRIPTION DRUG PROGRAM

Retiree Medical Benefits under the Retiree Plan end when you (or your spouse) become eligible for Medicare, usually at age 65. For Medicare-eligible retirees, the Retiree Plan provides a post-65 pharmacy benefit under the Affinity Rx Prescription Drug Program. The Program covers up to \$1,000 of prescription drugs each year. A copayment of \$5 for each prescription of generic drugs and \$10 for each brand name drug prescription. If you refuse the approved available generic equivalent you must pay the \$10 copayment plus the difference in cost between general and brand. This coverage requires that you make minimum monthly contributions based on your years of service in the Welfare Fund. The Affinity Rx Prescription Drug Program is administered by Blue Cross/Blue Shield of Michigan.

YOUR ELIGIBILITY FOR THE AFFINITY Rx PRESCRIPTION DRUG PROGRAM

To be eligible for the Affinity Rx Prescription Drug Program, you must reach the eligible age for Medicare participation or be eligible for Medicare due to a disability and:

- have had contributions under a Welfare Fund plan that provided retiree coverage (either by an employer or self-contributions at the applicable COBRA rate) made on your behalf for at least 40 weeks in each of the five consecutive 52-week periods immediately before retirement or at least 40 weeks in seven out of the ten consecutive 52-week periods immediately preceding retirement; *except that*
- for periods while you performed *seasonal work* (as defined under “Definitions”), contributions must have been made under a Welfare Fund plan that provided retiree coverage for an *average* of at least 40 weeks per 52-week period for five consecutive 52-week periods immediately before retirement, or, an *average* of at least 40 weeks per 52-week period for seven out of the ten consecutive 52-week periods immediately before retirement (the appropriate test will be applied pro rata based on the type of work in which you were engaged during the measuring period);
- not be engaged in Prohibited Employment;
- elect coverage under the Affinity Rx Prescription Drug Program by filing an election form with the Welfare Fund Office within 90 days following the later of your Retirement date or the date your coverage under the Retiree Medical Program ends as a result of eligibility for Medicare; and
- make contributions required for coverage by the 20th day of the month before the month for which coverage is provided. *For example, your payment for coverage in July is due by June 20th.*

WHEN YOUR COVERAGE UNDER THE AFFINITY Rx PRESCRIPTION DRUG PROGRAM ENDS

Your Affinity Rx Prescription Drug Program coverage will end on the earliest of the following dates:

- the date of your death;
- the date you become eligible for coverage under a Welfare Fund Plan as an active employee;
- the date you engage in Prohibited Employment;
- the date the Welfare Fund fails to receive your monthly contribution when due; or
- the date the Affinity Rx Prescription Drug Program or the Retiree Plan is terminated by the Trustees or an amendment to the benefit makes you ineligible for the Affinity Rx Prescription Drug Program.

If your coverage under the Affinity Rx Prescription Drug Program ends because you engage in Prohibited Employment, you will not be allowed to re-elect this benefit.

You may not defer election of coverage under the Affinity Rx Prescription Drug Program. If you fail to file an election on time you will lose your eligibility for the benefit. However, if you demonstrate that your failure to file an election on time was due to circumstances beyond your control, then the Trustees may, in their discretion, allow you to file a late election.

YOUR SPOUSE'S ELIGIBILITY FOR THE AFFINITY Rx PRESCRIPTION DRUG PROGRAM

If you die before your eligible spouse, your spouse may continue coverage under the Affinity Rx Prescription Drug Program until his or her death if your spouse makes the required monthly contribution. However, the continued coverage is subject to the Trustees' right to terminate or amend the benefit to make spouses ineligible.

HOW THE AFFINITY PRESCRIPTION DRUG PROGRAM WORKS

Where and How You Fill Your Prescriptions

You need to fill your prescriptions at a Blue Cross/Blue Shield network pharmacy to receive the Affinity Rx program savings. Approximately 98% of the pharmacies in Michigan participate in this program.

If you are not sure whether your pharmacy is a network pharmacy, ask your pharmacy technician or the pharmacist whether the pharmacy participates in the Affinity Rx Prescription Drug Program. If the pharmacy participates, be sure to present your Blue Cross/Blue Shield identification card.

The Cost of Your Prescriptions

After you reach the \$1,000 calendar year maximum, you must cover the cost of any additional prescription drugs that you need. After you meet the maximum, however, the Retiree Plan's Affinity Rx Prescription Drug Program allows you to purchase prescription drugs at the Blue Cross/Blue Shield pre-negotiated rate rather than at the full retail price so that you will continue to save money under the program. This program may save you approximately 13% and in some cases up to 20% of the retail price.

The amount of your savings may vary depending on the type of drug dispensed and where you have your prescription filled. You should also keep in mind that if your pharmacy offers senior discounts or has other cost-saving incentives, you may already be getting the best price for your prescription. Your pharmacy will determine which program provides you with the greatest savings.

Monthly Contribution Rate for Affinity Rx Prescription Drug Program Coverage

Your monthly contribution rate for coverage under the Affinity Rx Prescription Drug Program is based on your years of participation with the Welfare Fund, according to the following chart.

Monthly Contribution Rate for Affinity Rx Prescription Drug Program

Years of Service	Rate Per Person
5–10	\$18.00
11–15	\$16.00
16–20	\$14.00
20 or More	\$10.00

What's Not Covered by the Affinity Rx Prescription Drug Program

Affinity Rx savings do not apply to:

- 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;
- any drug labeled “Caution: Limited by Federal Law to Investigational Use” or 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;
- 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 spouse 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 specific conditions being treated;
- drugs or services covered by government-sponsored health care programs, such as Medicare or CHAMPUS; and
- any expenses shown in General Exclusions and Limitations on page 27.

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.

GENERAL EXCLUSIONS AND LIMITATIONS

The following are not covered under this Plan:

- organ or tissue transplant procedures that began after you became covered under the Retiree Plan; if you are continuing a transplant procedure that you began while covered by the Plan for active employees and you retired during any of the transplant phases, then you will receive a total of the maximum benefit as explained in the section Continuation of Transplant Benefits;
- 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 spouse incur that you or your eligible spouse 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 spouse 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 the Retiree Plan, if such benefits are payable or required to be covered under other insurance or applicable state law;
- NO Retiree Plan benefits will be paid for automobile-related injury or illness on behalf of you or your spouse as 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

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 or for benefits under the Affinity Rx Prescription Drug Program. See page 10 for more information about using your Blue Cross Blue Shield card.

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. 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;
- 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 Retiree Plan. The Welfare Fund has the right to recover overpayments by deducting the overpayment amount from future benefits payable to or on behalf of you or your spouse.

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 a member 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 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.

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.

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 Plan 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 Plan; or
- you are subject to a domestic relations order or child support order that meets the requirements of a Qualified Domestic Relations Order (QDRO) or a Qualified Medical Child Support Order (QMCSO) under the Employee Retirement Income Security Act of 1974 (ERISA).

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

MEDICARE ELIGIBILITY

You are no longer eligible for coverage under the Retiree Medical Program when you reach the eligibility age for Medicare coverage or early Medicare eligibility (under Part A or Part B) because of disability. For more information about Medicare benefits, contact your local Social Security Administration office. To receive enrollment materials, call 1-800-772-1213.

YOUR RIGHTS UNDER ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

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

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

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

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

ASSISTANCE WITH YOUR QUESTIONS

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration. For single copies of publications, contact the Pension and Welfare Benefits Administration Brochure Request Line at (800) 998-7542 or contact the PWBA field office nearest you.

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

PLAN ADMINISTRATION INFORMATION

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

Name and Address of Plan

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

Plan Sponsor

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

Employer Identification Number (EIN)

38-1328578

Plan Number

501

Type of Welfare Plan

This Plan provides medical 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.

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.

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

Dependent for purposes of this Retiree Plan means only your spouse.

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.

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.

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 or Retiree Plan means the program of benefits described in this booklet as may be amended from time to time.

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.

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.

Retirement Date means the date you are no longer covered by the Welfare Fund as an active employee because you have retired.

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.

Teamster Pension Fund means a pension plan maintained pursuant to a collective bargaining agreement or collective bargaining agreements between one or more employers and the International Brotherhood of Teamsters or its local unions or affiliates (i.e., Central States, SE & SW Areas Pension Fund).

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 document, 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 Retiree Plan.

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

Welfare Fund means the Michigan Conference of Teamsters Welfare Fund.