Michigan Conference of Teamsters Welfare Fund

MCTWF Actives Plan
MCTWF Retirees Plan
November 2015
IMPORTANT – PLEASE NOTE

This Summary Plan Description Booklet, together with your Schedule of Benefits and any material modifications thereof as published hereafter in the Michigan Conference of Teamsters Welfare Fund’s (otherwise hereafter referred to as “the Fund”, “our”, “we”, or “us”) newsletter, the Messenger, constitute your Summary Plan Description for the MCTWF Actives Plan and MCTWF Retirees Plan.

PLEASE REFER TO YOUR SCHEDULE OF BENEFITS TO DETERMINE WHAT BENEFITS ARE COVERED IN YOUR BENEFIT PACKAGE AND YOUR COST SHARING REQUIREMENTS.

If you have any questions about your benefits, please contact the Fund’s Member Services Call Center.

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MCTWF Actives Plan
MCTWF Retirees Plan

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2700 Trumbull Avenue
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(313) 964-2400 or (800) 572-7687
www.mctwf.org
For verification of eligibility, benefits or to determine the status of a claim, please call the Fund's Member Services Call Center -

Local Calls ....................................................................................................................................................................(313) 964-2400
Toll free .........................................................................................................................................................................(800) 572-7687
Alternative Outage Number...........................................................................................................................................(800) 482-2219

For participating provider referrals, after hours, please call -
Blue Cross Blue Shield of Michigan (BCBSM) ........................................................................................... (800) 810-2583
Delta Dental of Michigan .................................................................................................................................. (800) 524-0149

For prescription drug matters, please call -
CVS/caremark Mail Service and Retail Pharmacy .................................................................................... (888) 727-0495
CVS/caremark Specialty Pharmacy Services................................................................................................ (800) 237-2767

For prior authorization of medications for Acne, SSRI, Anti-Obesity, ADHD/Narcolepsy (age 20 and above), Anabolic Steroids, Compound, Oral Anti-Fungal and Brand Proton Pump Inhibitor (PPI) or generic PPI treatment greater than 90 days per one year period, providers must call -
CVS/ caremark ........................................................................................................................................................ (800) 626-3046

For prior authorization of Skilled Nursing Facility care, providers in Michigan must call BCBSM. Non-BCBSM and Non-Michigan providers must call the Fund's Utilization Review Department -
Blue Cross Blue Shield of Michigan ................................................................................................................. (800) 482-4040
The Fund’s Utilization Review Department......................................................................................................... (800) 572-7687 ext. 428

For prior authorization of Inpatient Hospital Medical Admission, Non-BCBS providers must call -
The Fund’s Utilization Review Department............................................................................................................. (800) 572-7687 ext. 428

For prior authorization of Non-emergent Outpatient CT Scans, Echocardiography Services, MRIs, PET Scans, In-Lab Sleep Studies and Nuclear Cardiology, providers in Michigan must call BCBSM. For prior authorization of Non-emergent Outpatient CT Scans, Echocardiography Services, MRIs, PET Scans, In-Lab Sleep Studies and Nuclear Cardiology Non-BCBSM and Non-Michigan providers must call the Fund’s Utilization Review Department -
Blue Cross Blue Shield of Michigan - American Imaging Management ....................................................... (800) 728-8008
The Fund’s Utilization Review Department.......................................................................................................... (800) 572-7687 ext. 428

For prior authorization of Human Organ Transplant procedures, providers in Michigan call BCBSM. Non-BCBSM and Non-Michigan providers must call the Fund’s Utilization Review Department -
Blue Cross Blue Shield of Michigan ...................................................................................................................... (800) 242-3504
The Fund’s Utilization Review Department.......................................................................................................... (800) 572-7687 ext. 428

For prior authorization of Inpatient Mental Health and Substance Use Disorder treatment, providers must call -
Blue Cross Blue Shield of Michigan .................................................................................................................... (800) 762-2382

For Applied Behavioral Analysis, providers must call -
Blue Cross Blue Shield of Michigan ....................................................................................................................... (877) 563-9347

For Medical, Dental, Optical and Hospital claims fraud matters, please call -
For Professional Medical or Vision claims - call the Fund...................................................................................(800) 637-6907
For Dental claims - call Delta Dental of Michigan ............................................................................................. (800) 524-0147
For Hospital claims - call Blue Cross Blue Shield of Michigan ............................................................................. (800) 482-3787
INTRODUCTION - MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

This Summary Plan Description Booklet (“Booklet”), which provides general information about the MCTWF Actives Plan and MCTWF Retirees Plan together with your Schedule of Benefits and Messenger newsletters published hereafter, or other statements of material modifications, comprise your Summary Plan Description (“SPD”). The SPD is the Master Plan Document. It is available for your review at 2700 Trumbull Avenue, Detroit, Michigan 48216 between 8:30 a.m. and 5:00 p.m. on regularly scheduled business days.

For simplicity, unless otherwise stated, the SPD Booklet refers to “You” for both the Participant and the Participant’s eligible Beneficiaries, “he” when solely referring to the Participant and “she” when solely referring to the Participant’s Spouse. Document names are italicized and defined terms are capitalized. Definitions are provided at the end of this Booklet.

The SPD will help You understand your benefits and use them well. You should review it with those of your family members Covered by your MCTWF Actives Plan or MCTWF Retirees Plan. It will give You an understanding of -

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

If your Plan benefits are amended, You will be notified through the Messenger or other statement of material modification.

Be sure to keep your SPD in a safe and convenient place. You also may access each of these documents on the Fund’s website, www.mctwf.org which also provides, for your further convenience, a Compilation of Messenger Notifications and other material modifications. If there is anything about the SPD that You don’t understand, contact our Member Services Call Center for assistance.

You may also obtain valuable information that will help You find the things You need to know about your benefit package on Michigan Conference of Teamsters Welfare Fund’s website at www.mctwf.org.

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 MCTWF Actives Plan or MCTWF Retirees Plan is terminated, the Trustees may use its remaining assets, after paying claims, to pay its remaining expenses, or may contribute those remaining assets to a new welfare benefit plan established through collective bargaining.

The Fund will terminate your coverage if the Trustees, in their sole discretion, determine that You, or your legal representative, knowingly provide false information, directly or indirectly, with the intent to cause the MCTWF Actives Plan or MCTWF Retirees Plan to provide coverage, benefits, or payments that You or a third party is not entitled to receive. Any act, practice, or omission by an individual that constitutes fraud or an intentional misrepresentation of material fact to MCTWF Actives Plan or MCTWF Retirees Plan is prohibited and the Trustees may terminate your benefit eligibility as a result. Failure to provide timely notice to your MCTWF Actives Plan and MCTWF Retirees Plan of a change in status, including, but not limited to, a change in status resulting from divorce, a change in your employment status (i.e., layoff, termination, quit, sick, personal leave, retirement, military leave, etc.) or eligibility for Medicare, is an intentional misrepresentation of material fact.
No document, including financial instruments such as checks or money orders, shall be presumed to have been received by the Fund unless actually received, regardless of the circumstances of mailing.
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### PART 18: NON-ALIENATION OF BENEFITS - MCTWF ACTIVES PLAN AND MCTWF RETIRES PLAN

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**Part 22: Important Definitions - MCTWF Actives Plan and MCTWF Retirees Plan**
The following are not Covered under the MCTWF Actives Plan and MCTWF Retirees Plan:

- Accidental Injury or Illness arising in the course of employment that is Covered under any workers’ compensation or occupational disease law or other state law or other insurance. Refer to Part 16: Assignment, Subrogation and Reimbursement for conditional exception to this exclusion;
- expenses incurred for care of injuries or Illnesses due to war or war-related acts;
- any expenses You incur that You are not legally required to pay;
- if you reside in the State of Michigan, no medical, prescription drug, or Weekly Accident and Sickness benefits will be paid under the MCTWF Actives Plan or MCTWF Retirees Plan for auto-related Accidental Injuries or Illnesses. This is due to Michigan’s no-fault automobile insurance law, which provides unlimited health care benefits to any person suffering an Accidental Injuries or Illnesses as a result of an automobile accident within the United States, its territories and possessions or in Canada. This rule does not apply to motorcycle-related Accidental Injuries or Illnesses that do not involve an automobile.
- if you reside outside the State of Michigan, no medical, prescription drug, or Weekly Accident and Sickness benefits will be paid under the MCTWF Actives Plan or MCTWF Retirees Plan for auto-related Accidental Injuries or Illnesses to the extent such benefits are payable pursuant to other insurance or applicable state law. Upon the submission of proof that such payable benefits have been exhausted or denied, and if denied, that all rights to appeal or otherwise dispute that denial have been exhausted, the Plan will provide scheduled benefits upon your execution of and compliance with the Michigan Conference of Teamsters Welfare Fund Assignment, Subrogation and Reimbursement Agreement. The Plan will not coordinate with any other plan or insurance carrier.
- in such cases where other medical coverage is available, no MCTWF Actives Plan or MCTWF Retirees Plan benefits will be paid for automobile-related Accidental Injury or Illness on your behalf if You are the operator or occupant of a rental vehicle;
- any surgery or medical care or service furnished by any facility contracted for or operated by the United States Government or by any other governmental unit for medical care or treatment unless a charge is made that You are legally required to pay;
- charges for completing claim forms or missed appointments;
- claims made for benefits beyond fifteen months from the date the expense was incurred (i.e., the date services were rendered);
- Accidental Injury or Illness suffered while in the armed forces of the United States;
- in such case where a MCTWF Retirees Plan Participant and/or his Spouse, or a COBRA Beneficiary becomes eligible for Medicare coverage, no MCTWF Retiree Plan benefits will be paid; and
- repair or replacement made necessary because of loss or damage due to misuse, mistreatment or theft.
SEC. 2.1: MCTWF ACTIVES PLAN

2.1(a) ENROLLING IN THE PLAN

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

You must complete this card in an accurate and timely manner and You may update your information by providing the Fund with a revised enrollment card which is available by calling the Fund’s Member Services Call Center or from the Forms page of the Fund’s website. If the Fund receives a claim for You or one of your Beneficiaries, processing your claim and reimbursing your expenses will be delayed or your benefits will be suspended if You have not -

• completed the Enrollment Card;
• provided accurate information; and
• notified the Fund of changes in the information You provided.

Below is a list of Beneficiary status’ that require documentation of eligible Beneficiary’s relationship, required documentation and each familial situation they pertain to:

**Beneficiaries on your Enrollment Card:**

<table>
<thead>
<tr>
<th>Spouse</th>
<th>• Marriage Certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural children</td>
<td>• Birth Certificate; or</td>
</tr>
<tr>
<td></td>
<td>• Certified copy of Affidavit of Parentage (sometimes referred to as paternity acknowledgement); or</td>
</tr>
<tr>
<td></td>
<td>• Order of Filiation and Support; or</td>
</tr>
<tr>
<td></td>
<td>• National Medical Support Notice.</td>
</tr>
<tr>
<td>Children not listed on original enrollment card</td>
<td>• Birth Certificate; or</td>
</tr>
<tr>
<td></td>
<td>• Certified copy of Affidavit of Parentage (sometimes referred to as paternity acknowledgement); or</td>
</tr>
<tr>
<td></td>
<td>• Order of Filiation and Support; or</td>
</tr>
<tr>
<td></td>
<td>• National Medical Support Notice.</td>
</tr>
<tr>
<td>Step children</td>
<td>• Birth Certificate; and</td>
</tr>
<tr>
<td></td>
<td>• When applicable, portion of the finalized Judgment of Divorce, that includes names of the parties, names of children, who has custody and who has financial responsibility for the children's health care expenses; and</td>
</tr>
<tr>
<td></td>
<td>• Marriage Certificate to the natural parent of the stepchild.</td>
</tr>
<tr>
<td>Adopted children</td>
<td>• Order Placing Children After Consent; or</td>
</tr>
<tr>
<td></td>
<td>• Order of Adoption.</td>
</tr>
<tr>
<td>Disabled children ages 26 and greater</td>
<td>• Birth Certificate; and</td>
</tr>
<tr>
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<td>• Statement from physician, psychologist or psychiatrist documenting the child’s total and permanent disability (see Sec. 2.1(d), Covering Your Beneficiaries); and</td>
</tr>
<tr>
<td></td>
<td>• If disability began before child was covered under MCTWF Actives Plan, adequate evidence that child was covered under immediately preceding health plan; and</td>
</tr>
<tr>
<td></td>
<td>• Attestation that child is unmarried.</td>
</tr>
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</table>
2.1(b) UPDATING ENROLLMENT INFORMATION

Family Status Changes
Changes in family status are marriage, divorce, death, birth, placement for adoption, adoption, new dependent child status due to Total and Permanent Disability, cessation of dependent child status or a change in your Spouse’s primary group health, dental or vision insurance carrier. You must notify the Fund immediately when you have a change in family status and complete and return the Fund’s Change in Family Status Form, along with the appropriate documentation (see Sec. 2.1(a) for the list of required documentation) (a) in the event of marriage, birth, placement for adoption, or adoption to ensure eligibility for coverage for your new Spouse or dependent child as of the status change date, or (b) in the case of divorce, death, or cessation of dependent child’s status to avoid responsibility for benefits paid by the Fund, for which it will pursue you (and in the case of divorce, your ex-Spouse, jointly and severally) due to your failure to immediately inform the Fund of the status change.

If the status change involves a new Spouse or dependent child and your Employer contributes under a “tiered” contribution rate structure, your Employer will be responsible for payment of any additional contributions required to provide your new Spouse or dependent child coverage, retrospectively and prospectively. If, in such case, you fail to notify the Fund of a new Spouse or dependent child within 60 days of that event, eligibility for retroactive coverage will begin on the date 60 days prior to the Fund’s receipt of such notification.

If the status change involves the loss of your Spouse or your child, or the divorce of your spouse, or the loss of dependent status of your child, or, if a MCTWF Retiree Plan Participant or Beneficiary becomes entitled to early Medicare eligibility, coverage will cease as of midnight of the date on which the status change occurs and the Fund will pursue you and your Spouse, or ex-Spouse for recovery of benefits paid for services incurred thereafter as the result of your failure to immediately inform the Fund of the status change. A delay in such notification of more than 60 days also will result in loss of entitlement to elect COBRA continuation coverage.

Participant Information Changes
In order for the Fund to communicate with you and provide you with information about the MCTWF Actives Plan, having a record of your current address, telephone number and email address is necessary. To provide this information you must notify the Fund in writing by completing the Fund’s Contact Update Form. Both the Change in Family Status Form and the Contact Update Form are available on the Forms page of the Fund’s website.

Qualified Medical Child Support Orders (QMCSOs)
A Qualified Medical Child Support Order (QMCSO) is a court order providing for child support, usually resulting from a divorce or legal separation that:
- designates one parent to pay for a child’s health Plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent’s health care Plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies; and
- identifies each health care Plan to which the QMCSO applies.
If a court has issued an order with respect to health care coverage for any of your Dependent children, the Fund will determine if the court order is a QMCSO as defined by federal law.

The Fund’s determination will be binding on You, the other parent, the child and anyone acting on the child’s behalf.

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

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

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

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

2.1(c) ELIGIBILITY FOR COVERAGE

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

Eligibility for Coverage Based on Weekly Contributions

If You are actively employed on the date your Employer starts participating in the MCTWF Actives Plan, You are eligible for immediate coverage under the MCTWF Actives Plan. Upon the Fund’s receipt of at least one week of Employer Contributions on behalf of a newly hired Employee, eligibility for MCTWF Actives Plan coverage will commence on the first day (Sunday) of that first contribution week.

If You are on layoff the day your benefits would normally become effective and You return to active employment, your coverage will begin upon your return. However, if your eligibility for coverage ceases as a result of layoff, eligibility will be reinstated upon resumption of active Covered employment.
If you are retired and covered under an active benefit plan, benefit eligibility for you or your spouse (if applicable) ceases as of the earlier of (a) the first of the month in which you or your spouse attains age 65, or (b) the date you or your spouse becomes eligible for early medicare part A coverage.

You are covered for benefits under the MCTWF Actives Plan only for weeks for which your employer has made contributions to the fund on your behalf, except as you may be entitled to extended coverage through application of benefit bank weeks (see Sec. 2.1(h), Benefit Bank Weeks) or due to a non-work related disability (see Sec. 4.2, Continuation of Benefit Eligibility) or due to your COBRA continuation coverage participation (Sec. 2.1(o), COBRA Continuation Coverage). You must have a contribution reported for the week services are received to be eligible for benefits.

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

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

- If you are currently eligible for MCTWF Actives Plan benefits based upon weekly contributions made (and benefit bank weeks applied) on your behalf, the fund will convert weekly contributions made (and benefit bank weeks applied) for the two calendar months prior to the effective date of the change to hourly or daily contributions to create immediate eligibility. Remaining benefit bank weeks will be available to you only upon future reestablishment of participation pursuant to weekly contributions.

- If you are not currently eligible for MCTWF Actives Plan benefits, coverage will begin on the first day of the second month following the month in which the minimum number of required hours or days is contributed by the employer. The minimum number of hours or days required may be established during two consecutive months if necessary.

- Once initial eligibility is established it is maintained from month to month if the minimum number of required hours or days is contributed by the employer. Excess hours or days, i.e., those in excess of the minimum number of required hours for a four week month and those in excess of the minimum number of required hours or days for a five week month, are converted to a Dollars Bank, using the then current hourly or daily contribution rate. The Dollars Bank is used to supplement succeeding months in which employer contributions fall below the minimum number of required hours or days, by reconverting dollars to hours or days using the then current hourly or daily contribution rate.

- The Dollars Bank is also used to extend eligibility (in full monthly units only), during months of non-payment by the employer, e.g., layoff, personal leave, voluntary or involuntary terminations, etc. The Dollars Bank may not be used for any other purpose or cashed out.

- When the Dollars Bank is insufficient to establish a full month’s eligibility, self-contributions at the employer rate may be made by you to supplement the Dollars Bank. Self-contributions must be made within 15 days of the date of the fund’s invoice. Failure to supplement will result in loss of coverage and will freeze use of the Dollars Bank until receipt of employer contributions.
• If the contribution shortage is not supplemented by You at the Employer contribution rate, You will be offered COBRA continuation coverage (see Sec. 2.1 (o), COBRA Continuation Coverage).
• The Fund will issue You a monthly account statement reflecting the most recent Contributions made on your behalf, the period for which eligibility, if any, has been established, and your current Dollars Bank balance.

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

Your Beneficiaries are -
• your Spouse;
• your natural or step child, or child who has been placed with You for adoption, or whom You have adopted, age 18 and under;
• your natural or step child, or child who has been placed with You for adoption, or whom You have adopted, age 19 through the end of his 26th birthday month; and
• your natural or step child, or child who has been placed with You for adoption, or whom You have adopted, regardless of age (except that such child over the age of 26 must be unmarried), who has been determined by a Physician, psychologist or psychiatrist to be Totally and Permanently Disabled. If your disabled child is age 26 or greater and the Disability began before the child was Covered under the MCTWF Actives Plan, the Participant must present adequate evidence that the child was covered as your dependent under your health Plan on the day immediately preceding your MCTWF Actives Plan coverage.

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

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

2.1(e) LOSS OF ELIGIBILITY
As a general rule, You will lose eligibility for benefits under the MCTWF Actives Plan, under any of the following circumstances:
• your employment with a Contributing Employer ends;
• your Employer stops making Contributions to Michigan Conference of Teamsters Welfare Fund on your behalf;
• You stop making self-Contributions;
• your death;
• your Employer no longer participates with the Fund; or
• the Trustees of the MCTWF Actives Plan change, amend or terminate the MCTWF Actives Plan.

Notwithstanding the general rule, your eligibility for benefits may continue if You -
• are eligible for benefit bank weeks;
• are eligible to receive weekly accident and sickness benefits;
• are eligible to purchase COBRA continuation coverage and You make the required payments on time; or
• are eligible for specified periods for leaves of absence under the Family and Medical Leave Act and under the Uniformed Services Employment and Reemployment Rights Act.

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

2.1(f) IF YOUR EMPLOYMENT ENDS

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

Termination

If You voluntarily end your employment or are discharged and -

• your Employer contributes on a weekly basis, your coverage will end at midnight on Saturday of the last week for which your Employer last makes Contributions to the Fund on your behalf; or

• your Employer contributes on an hourly or daily basis, your coverage will end on the last day of the month for which Contributions met the minimum requirement for monthly coverage.

When your coverage ends You may be eligible to purchase COBRA continuation coverage (see Sec. 2.1 (o), COBRA Continuation Coverage).

Layoff

If You are laid off and your Employer ceases making Contributions to the Fund on your behalf, your medical and prescription drug benefits will remain in effect for as long as You have remaining benefit bank weeks if your MCTWF Actives Plan provides benefit bank weeks. When your benefit bank weeks run out, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.1 (o), COBRA Continuation Coverage).
2.1(g) IF YOUR EMPLOYER WITHDRAWS FROM MCTWF ACTIVES PLAN PARTICIPATION

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

2.1(h) BENEFIT BANK WEEKS

Using Your Benefit Bank Weeks

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

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

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

If benefit bank weeks are available to You and You are an Employee of a newly Participating Employer or a newly hired employee of an already participating employer, You will become entitled to benefit bank weeks once Contributions have been made on your behalf for 8 consecutive weeks, or 9 out of 13 weeks.

If You are not actively employed and are still covered by remaining benefit bank weeks before the date on which the defined period of benefit bank weeks availability expires, You will continue to be so covered until your benefit bank weeks are exhausted. Upon your return to Active employment and the payment of Contributions on your behalf, You will receive a new allotment as specified in your Schedule of Benefits for the new defined period.
Benefit bank weeks may be used to continue your MCTWF Actives Plan’s medical, dental, vision, and prescription drug benefits, however, no weekly accident and sickness, total and permanent disability, or death benefits will be available to cover such services or events when incurred during benefit bank weeks.

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

- if your MCTWF Actives Plan benefit package does not provide benefit bank week coverage;

- if You quit.

**2.1(i) STRIKE OR LOCKOUT**

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

- the strike must be sanctioned by the International Brotherhood of Teamsters (IBT) or the locked out employees must be supported, as evidenced by payment of IBT strike wages;

- the Fund must receive written confirmation of strike sanctioning or support from the IBT which must include the inception and termination dates, the name of the Employer, and a list of affected Participants, along with other necessary information, from your Local Union;

- coverage will not be provided if You are on leave of absence, sick leave (until your return from leave), layoff, or have been terminated;

- your Employer must not be more than 30 Days delinquent in making required Contributions to the Fund at the commencement of the temporary work stoppage;

- your unused benefit bank weeks will be applied immediately so as to avoid a lapse in your medical and prescription drug benefits. After all your benefit bank weeks have been exhausted, coverage will continue during the temporary work stoppage for a maximum of eight weeks, subject to your ongoing compliance with the Local Union’s requirements for strike duty. After that, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.1 (o), COBRA Continuation Coverage). The temporary work stoppage is a COBRA qualifying event. Consequently, the COBRA coverage continuation period commences on the date of the temporary work stoppage. The number of benefit bank weeks used plus the eight weeks of extended MCTWF Actives Plan coverage during the temporary work stoppage will offset the number of weeks of COBRA continuation coverage that You will be entitled to purchase; and

- during the temporary work stoppage, non-bargaining unit employees will receive a maximum of seven weeks extended coverage contingent on the Employer’s payment of advance Contributions for that period.

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

You will lose eligibility for benefits under the MCTWF Actives Plan and the Fund will not accept Contributions on your behalf during any period that You work during a temporary work stoppage by your bargaining unit that is sanctioned by the International Brotherhood of Teamsters.
2.1(j) LEAVES OF ABSENCE

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

For those Employers to whom the FMLA applies, Basic Leave Entitlement is available -
• for your own serious illness or incapacity due to pregnancy, prenatal medical care or child birth;
• to care for your newborn child or newly adopted child; or
• to care for your seriously ill Spouse, parent or child.

For those Employers to whom the FMLA applies, Military Family Leave Entitlement is available -
• to Participants with a Spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation to address certain qualifyiing exigencies which may include attending certain military events, arranging for alternate childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings; or
• to care for a covered service member who has a serious Accidental Injury or Illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary Disability retired list.

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

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

If your Employer grants You further leave beyond the permissible FMLA period but stops making Contributions to the Fund on your behalf, and if You have available benefit bank weeks, You have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see Sec. 2.1 (o), COBRA Continuation Coverage).

Military Leave
If You are on leave because of military service -
• for less than 31 Days, coverage during that leave period will continue at no cost to You; and
• after 30 Days, if You have available benefit bank weeks, You have the option of when to apply them by submitting to the Fund written instructions prior to commencement of military leave which will delay the application until discharge from military duty. Otherwise, You may be eligible to continue your medical coverage at your own expense for the lesser of 24 months beginning on the day the uniform leave commences, or a period ending on the day after you fail to return to employment within the time allowed by Uniformed Services Employment and Reemployment Rights Act (USERRA). You must notify the Fund upon your release from service, but by no later than the following USERRA time limits for returning to work:
o Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period.

o 31 to 180 days: The employee must apply for reemployment no later than 14 days after completion of military service.

o 181 days or more: The employee must apply for reemployment no later than 90 days after completion of military service.

o Service-connected injury or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

Other Leaves
If You take any other leave of absence and your Employer stops making Contributions to the Fund on your behalf, and if You have available benefit bank weeks, You have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see Sec. 2.1 (o), COBRA Continuation Coverage).

2.1(k) ACCIDENTAL INJURY OR ILLNESS
If You are unable to work due to Accidental Injury or Illness and your Employer is not obligated to make further Contributions to the Fund on your behalf, your medical and prescription drug benefits will remain in effect for as long as You have benefit bank weeks remaining. However, if You are receiving weekly accident and sickness benefits from your MCTWF Actives Plan benefit package, your coverage will continue for as long as that benefit is being paid (see Sec. 4.2, Continuation of Benefit Eligibility), after which remaining benefit bank weeks are applied. When your benefit bank weeks run out, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.1 (o), COBRA Continuation Coverage).

2.1(l) REINSTATEMENT OF COVERAGE
If your eligibility for coverage has ended because You were laid off or no longer working for a Contributing Employer, and then You return to work for a Contributing Employer, your eligibility for coverage will be reinstated upon your return as of the first day (Sunday) of the week for which Contributions resume on your behalf.

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

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

If your coverage ends because You begin active military service and your period of military service is more than 30 Days but less than 181 Days, your coverage will be reinstated if You apply for reemployment with your former Contributing Employer within 14 Days after completion of the period of military service.
If, because of circumstances beyond your control, submitting an application within the 14-day period is impossible or unreasonable, the application must be submitted on the next first full calendar day when submitting the application becomes possible.

If your coverage had ended because You entered or were drafted into active military service for more than 180 Days, and then You return to work for a Contributing Employer, your Coverage will be reinstated as of the first day (Sunday) of the week for which Contributions have resumed on your behalf.

2.1(m) ACTIVES SURVIVOR HEALTH BENEFITS

If the participant dies while actively covered (see * below) under the MCTWF Actives Plan benefits package, his eligible spouse and dependent children will be provided with up to 36 months of free medical and prescription drug coverage.

Key Definitions

With respect to this benefit rule –

- “Survivor(s)” refers to the spouse and dependent children of the deceased participant who were eligible for MCTWF Actives Plan benefits on the date of the participant’s death.
- “Survivor Health Benefits” refers to the same base medical and prescription drug benefits that the deceased participant’s MCTWF Actives Plan participating group is covered for during the period of the survivors’ Survivor Health Benefits eligibility.
- “Active Coverage” refers to the participant’s eligibility for MCTWF Actives Plan base medical and prescription drug benefits while -
  - actively employed;
  - utilizing the Fund’s strike benefits;
  - utilizing benefit banks; or
  - utilizing Weekly Accident and Sickness benefits.

Eligibility - Initial and Ongoing

- Upon receipt of notification of the death of a participant who had Active Coverage on the date of his death, the Fund will notify the participant’s Survivors of their automatic eligibility for Survivor Health Benefits following the exhaustion of any remaining benefit bank coverage, for a maximum period (including the benefit bank coverage period) of 36 months following the coverage week in which the participant died. (*However, if at the time of death the deceased participant’s employer has ceased to maintain Fund benefits for the deceased participant’s MCTWF Actives Plan participating group, his survivors will not be eligible for Survivor Health Benefits.) Each Survivor, in the alternative, may elect COBRA continuation coverage.

- For each Survivor who does not elect COBRA continuation coverage, Survivor Health Benefits eligibility will continue as follows:
  - remarriage;
  - enrollment in the MCTWF Retirees Plan (Note: the spouse may defer enrollment until expiration of her Survivor Health Benefits coverage, but must comply with the Fund’s rules for timely application for MCTWF Retirees Plan coverage); or
  - Medicare eligibility.

- For each surviving child, for the earlier of 36 months or –
  - the end of the month in which the child turns age 26; or
  - the date of the child’s adoption by anyone other than the surviving spouse.
• The deceased participant’s MCTWF’s Actives Plan participating group’s medical and prescription drug benefits are suspended or terminated for any reason, the Survivor Health Benefits also will be suspended or terminated. MCTWF will require periodic status statements to ensure that each Survivor remains eligible.

**Benefit Design**

• Survivor Health Benefits always will mirror the design of the then current base medical and prescription drug benefits provided to the deceased participant’s MCTWF Actives Plan participating group. If the group’s base medical and prescription drug benefits change, so too will the Survivor Health Benefits.

**Coordination of Benefits**

• If a Survivor also is covered under another group health plan (including another Fund benefit package) or health insurance policy, Survivor Health Benefits coverage always will be secondary to that other plan or policy.

### 2.1(n) FLEXIBLE DEPENDENT COVERAGE PROGRAM

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

• You must have Beneficiaries unless You enrolled in the Program by December 31, 2006 and remained continuously enrolled and eligible in the Program thereafter (“grandfathered”) by virtue of the payment on your behalf of composite rate Contributions by your Employer;

• all of your Beneficiaries must have coverage under another group health plan, and You must provide proof to the Fund of the other coverage; and

• You must complete and submit the Fund’s *Flexible Dependent Coverage Program Election Form*.

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

**How to Enroll**

You must enroll in accordance with the rules that follow:

• You must enroll beginning in November for the upcoming calendar year if You are enrolling for the first time, by completing, signing and dating the *Flexible Dependent Coverage Program Election Form*, and returning it to the Fund no later than December 31. If You are a new Participant You must enroll within 30 Days of first becoming eligible under your MCTWF Actives Plan benefit package.

• You must submit proof of your Beneficiary’s other group health coverage with the *Flexible Dependent Coverage Program Election Form*.

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

**Change in Family Status**

You must notify the Fund immediately upon a change in family status to ensure proper handling of your claims if -
• You add a Beneficiary as a result of marriage, birth or adoption and that Beneficiary is not covered under another group health plan, your participation will cease in the Flexible Dependent Coverage Program; or

• your Beneficiaries were covered under another group health plan and lose that coverage, You may stop participating in Flexible Dependent Coverage Program at that time. You must provide proof of the loss of coverage.

SEC. 2.2: COBRA CONTINUATION COVERAGE - MCTWF ACTIVES PLAN

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

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

2.2(a) COVERAGE ENTITLEMENT PERIOD

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

When COBRA Continuation Coverage Continues For Up to 18 Months

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

• your termination of employment for reasons other than gross misconduct; or

• your reduction in employment hours.

When COBRA Continuation Coverage Continues For Up to 29 Months

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

If You already have COBRA continuation coverage for a period greater than 29 months, no additional extension will be granted because of Disability.
You must notify the Fund of the determination of Disability by the Social Security Administration within 60 Days after the determination.

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

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

When COBRA Continuation Coverage Continues For Up to 36 Months

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

• your death;
• your divorce;
• your child’s loss of Dependent status under the Plan;
• You become eligible for Medicare; or
• two or more qualifying events.

2.2(b) HOW TO ELECT COBRA CONTINUATION COVERAGE

A COBRA notice is sent to You upon notification to MCTWF of a qualifying event. Election of COBRA continuation coverage must be made no later than 60 Days from the date You are notified of a COBRA qualifying event. If the election is not received within 60 Days, You lose your right to COBRA continuation coverage. Remaining benefit bank week benefits are applied prior to elected COBRA continuation coverage benefits and each benefit bank week is counted toward your statutory COBRA continuation coverage entitlement period.

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

Medicare Enrolled Individuals Electing COBRA Continuation Coverage

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

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

Notifying the Fund of Beneficiary COBRA Qualifying Event

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

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

To help ensure that You do not lose coverage, the Fund recommends that You notify us as soon as possible of any events that can cause your coverage to end.
2.2(c) LOSS OF COBRA CONTINUATION COVERAGE

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

• You become covered under another group health plan. However, coverage may be continued if you have a health problem for which coverage is excluded or limited under the other group health Plan;

• your Employer stops participating in the Fund and your Employer provides coverage to the Employee group under another health Plan (in that event, the other health Plan will be required to offer COBRA for the remaining period of coverage). However, if you have a health problem for which you are receiving treatment, coverage for that condition will continue until that condition is covered by another Plan or you reach the time limits for COBRA continuation coverage;

• the required Contributions are not paid on time;

• the MCTWF Actives Plan is terminated;

• you become entitled to Medicare after the COBRA election; or

• your coverage has been extended to 29 months and it is determined that you are no longer disabled.

SEC. 2.3: MCTWF RETIREES PLAN

2.3(a) ELIGIBILITY FOR PARTICIPATION

The Retirement Date is the date an MCTWF Actives Plan Participant ceases to be Covered by the MCTWF Actives Plan as a result of retirement, after application of all remaining benefit bank weeks. However, for retiring MCTWF Actives Plan Participants age 50 or older, the purchase of COBRA continuation coverage may extend their Retirement Date until the cessation of such coverage. The following eligibility rules apply to retired individuals seeking to participate in the MCTWF Retirees Plan:

Retired Individuals Under Age 57

• Must be age 57 or older to enroll in MCTWF’s Retirees Plan (or to defer enrollment, see deferred participation), with the exception of “30-and-Out” Pensioners age 50 or older, who meet the eligibility rules for individuals age 57 or older.

“30-and-Out” Pensioners in a Teamster Pension Plan:

- Ages 50 to 56 – Must meet all of the eligibility rules for individuals age 57 or older and must provide proof of a “30-and-Out” pension at the time of timely application for MCTWF Retirees Plan enrollment or deferral.

- Under Age 50 – Must meet all of the eligibility rules for individuals ages 50 to 56 with a “30-and-Out” pension, and must defer participation in the MCTWF Retirees Plan until at least age 50 or later.

Retired Individuals Age 57 or Older - Standard Eligibility Rule

• Must have participated in an eligible MCTWF Actives Plan benefit package i.e., one that includes the retiree coverage component) and must have had Contributions made on his behalf for coverage under an MCTWF Actives Plan, at least 40 weeks in each of the five
consecutive 52 week periods immediately preceding the Retirement Date, or at least 40 weeks in seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date; except that for periods while the retired individual, as an MCTWF Actives Plan Participant, performed Seasonal Work, eligible Contributions must have been made for an average of at least 40 weeks per 52 week period for five consecutive 52 week periods immediately preceding the Retirement Date, or an average of at least 40 weeks per 52 week period for seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date (the appropriate test shall be applied pro rata based on the type of work in which the retired individual, as an MCTWF Actives Plan Participant, was engaged during the measuring period).

- Must not be eligible for Medicare coverage.
- Must not be engaged in Prohibited Employment (see Part 22: Important Definitions).

**Retired Individuals Age 57 or Older - Expanded Eligibility Rule**

- An individual need not retire in a MCTWF Actives Plan benefit package that includes the retiree coverage component. Sufficient prior participation in a package that does include the retiree coverage component, also will trigger eligibility for MCTWF Retirees Plan benefits. Self-contribution rates for participation in the MCTWF Retirees Plan are approximately 10% higher than the rates based on the Standard Eligibility Rules.

- For individuals who retire at age 62 or greater while covered by the MCTWF Actives Plan that does not include the retiree coverage component, participation in the MCTWF Retirees Plan eligibility for the Fund is conditioned on having accrued, at any time, 20 years of participation in any MCTWF Actives Plan benefit package that includes the retiree coverage component.

- For individuals who retire at age 57 or greater while covered by an MCTWF Actives Plan benefit package that does not include the retiree coverage component, eligibility for participation in the MCTWF Retirees Plan is conditioned on having accrued a minimum of seven of the immediately prior 10 years of participation in an MCTWF Actives Plan benefit package that includes the retiree coverage component, or a minimum of 10 of the immediately prior 15 years of participation in an MCTWF Actives Plan benefit package that includes the retiree coverage component.

- Once the requirements are met, the Participant will not lose his eligibility to enroll in a the MCTWF Retirees Plan solely by delaying his Retirement Date.

- The retired individual must not be eligible for Medicare coverage.

- The retired individual must not be engaged in Prohibited Employment (see Part 22: Important Definitions).

**2.3(b) RETIREES SUPPLEMENTAL BENEFITS RIDER**

The Retiree Supplemental Benefits Rider (Retiree Rider) supplements MCTWF’s Retirees Plan benefit package with hearing, vision and dental benefits, at a monthly cost-based Contribution rate, and is available at the time You enroll in MCTWF’s Retirees Plan. After the Retiree Rider is elected it may be dropped, following at least one year of Retiree Rider coverage, but You must notify the Fund in writing 45 days prior to the calendar month for which the Retiree Rider coverage is to terminate. For example, to drop coverage as of January 1st, the Fund must receive written notification by November 15th. Once the Retiree Rider coverage is dropped, it will not be available to You again.
2.3(c) UNIFORMED SERVICES (MILITARY LEAVE)
Uniformed Services credit may count toward satisfying MCTWF Retirees Plan enrollment requirements for required Years of service and for determining MCTWF's Retirees Plan medical benefit package self-Contribution rate.

In order to earn up to five Years of Uniformed Services Credit, all of the following conditions must be met:

• the retired individual must have entered the Uniformed Services while working for an Employer that contributed to the Fund (a “Fund Contributing Employer”) on his behalf for a MCTWF Actives Plan benefit package that included the Retiree coverage component;

• the retired individual’s military leave did not exceed five Years (except due to circumstances addressed in that section of USERRA entitled “Employment Rights of Persons Who Serve in the Uniformed Services”); and

• the retired individual must have applied for return to work with an MCTWF Actives Plan Contributing Employer within the following time frames:
  - within 90 Days after completed duty time of more than 180 Days; or
  - within 30 Days after completed duty time of 31 to 180 Days; or
  - within five Days after completed duty time of up to 30 Days.

2.3(d) PLAN ENROLLMENT REQUIREMENTS

• To enroll in the MCTWF Retirees Plan, the retired individual must complete and submit to the Fund an MCTWF Retirees Plan Enrollment Application within 90 Days immediately following the Retirement Date and, if approved, make timely payments as billed. Benefit coverage will commence effective the day following the retirement date. If the completed Application is received beyond the 90 Day window period, but within one Year of the MCTWF Retirees Plan Retirement Date (see Part 22: Important Definitions), and, if approved, and timely payment, as billed, is made, benefit coverage will commence as of the first day of the month that falls at least 90 Days after the Fund’s receipt of the application.

2.3(e) SELF-CONTRIBUTION RATES

• Retired individuals approved for enrollment in the MCTWF Retirees Plan must elect coverage under either the MCTWF Retirees Plan benefit package alone or in combination with the Retiree Rider and make the appropriate, timely self-contribution payment to the Fund, as billed. Thereafter, Contributions must be received on or before the 20th day of the month preceding the month for which coverage is provided. It is the responsibility of each Retiree and or Spouse to send timely payments to the Fund. Coverage under the MCTWF Retirees Plan will terminate if Contributions are not filed with the Fund within the time required. Contributions will be accepted if payment for the month past due is received by the 15th of the month following the month due, together with a $50 late fee. If the Participant is also eligible for Total and Permanent Disability (TPD) benefits, once he is approved for the MCTWF Retirees Plan benefits and the first contribution payment is made, he irrevocably loses his eligibility for TPD benefits.
• Self-Contribution rates are determined by two factors; years of Fund participation in a MCTWF Actives Plan benefit package that includes the retiree coverage component (“Years of service”) and the age of the retired individual at his MCTWF Retirees Plan Retirement Date. The self-Contribution rate covers both the retired individual and his eligible Spouse.

To be credited with a Year of service, the retiring individual must have had Contributions made on his behalf for at least 40 weeks in each of the five consecutive 52 week periods immediately preceding the Retirement Date, or at least 40 weeks in the seven out of ten consecutive 52 week periods immediately preceding the Retirement Date; except that for periods while the retired individual, as a MCTWF Actives Plan Participant, performed Seasonal Work, Contributions must have been made for an average of at least 40 weeks per 52 week period immediately preceding the Retirement Date.

* Self-Contribution rates are adjusted each April 1st based upon Plan experience and the retired individual’s age and years of service as of his MCTWF Actives Plan Retirement Date, except that resumed Covered employment in an MCTWF Actives Plan benefit package that includes the Retiree coverage component may result in a reduced self-Contribution rate (as addressed in the deferred Participation Section of this SPD).

2.3(f) COBRA CONTINUATION COVERAGE CONTRIBUTIONS

• Age 50 or older retiring Participants may choose to make COBRA continuation coverage Contributions to add to his Years of Fund service and/or age.

• Under age 50 retiring Participants may not count COBRA continuation coverage Contributions toward establishing his Retirement Date, with the exception of those with 25 or more Years of service in the Fund.

2.3(g) RESTRICTION ON PARTICIPATION

The right of a retiring individual to enroll in a MCTWF Retirees Plan benefit package is suspended upon the expiration of his Collective Bargaining Agreement (CBA) (except for otherwise eligible retirees at least age 57 with at least 30 years of participation in the Fund), and will remain suspended unless the parties agree to renew participation in an MCTWF Actives Plan benefit package, retroactive to the prior CBA’s expiration date. In such case, the retired individual’s right to enroll is retroactively restored. For this purpose only, the definition of Retirement Date excludes the application of remaining benefit bank weeks, if by their application, the retired individual’s eligibility to enroll in the MCTWF Retirees Plan would be suspended because such date falls in the post CBA expiration period.

2.3(h) ELIGIBILITY FOR DEFERRED PARTICIPATION

Pre-Enrollment Voluntary Deferrals

• Retired individuals whose application for enrollment in the MCTWF Retirees Plan has been approved, may defer enrollment upon written request. The retired individual must notify the Fund at such time as he wishes to commence participation. The self- Contribution rate will be calculated, in part, based upon the age of the retired individual at the commencement of participation. If at the time of commencement of participation the retired individual can newly satisfy MCTWF’s Retirees Plan initial eligibility rules the self-Contribution rate will be recalculated to reflect the additional year(s) of service
Pre-Enrollment Automatic Deferrals

• “30-and-Out” Pensioners who are under age 50 whose application for enrollment in the MCTWF Retirees Plan has been approved, subject to attaining age 50, will be automatically deferred until age 50 or later. The retired individual must notify the Fund at such time as he wishes to commence participation. The self-Contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

• Retired individuals who are age 50 to 56, and who are not “30-and-Out” Pensioners, whose application for enrollment in the MCTWF Retirees Plan has been approved, subject to attaining age 57 will be automatically deferred until age 57 or later. The retired individual must notify the Fund at such time as he wishes to commence participation. The self-Contribution rate will be calculated based upon the age of the retired individual at the commencement of participation.

Post Enrollment Voluntary Deferrals

• Retired individuals may defer participation any number of times after enrollment in a MCTWF Retirees Plan benefit package, upon written request to the Fund during the open enrollment period each year from November 1st through December 10th, which will permit resumption of participation as of January 1st. However, the deferral period must be at least six months. At such time as the retired individual seeks to resume participation in a MCTWF Retirees Plan benefit package. The self-Contribution rate will be calculated based on the retired individual’s age and Years of service at the time of the initial commencement of participation in the MCTWF Retirees Plan.

If the deferral is for the purpose of resuming employment, there may be a period of time before eligibility is established for the new employment based coverage. Therefore, the retired individual may continue the MCTWF Retirees Plan participation by paying his monthly self-Contribution until eligibility for the new coverage is established.

If by virtue of MCTWF Actives Plan participation during the deferral period, the deferring individual can newly satisfy MCTWF’s Retirees Plan initial eligibility rule, the self-Contribution rate will be recalculated to reflect the additional year(s) of service earned and the age of the retired individual at the commencement of resumed coverage under MCTWF’s Retirees Plan participation.

The same right of post-enrollment, voluntary deferrals to which the retired individual is entitled applies to the retiree Spouse who is participating in the MCTWF Retirees Plan separately to which the retired individual is entitled. In the event that the retiree Spouse elects COBRA continuation coverage, her right to coverage under a MCTWF Retirees Plan benefit package will be deemed deferred for the duration of her COBRA continuation coverage (see the Covering Your Spouse section of this SPD).

Post Enrollment Automatic Deferrals

• If either a retired individual or retiree Spouse fails to pay Self-Contributions when due, he or she will be placed in an automatic deferred status and may re-enroll in the MCTWF Retirees Plan by notifying the Fund, in writing, of his/her intent to re-enroll. Application for re-enrollment must occur during the annual open enrollment period from November 1st through December 10th, which will permit resumption of participation as of January 1st contingent upon timely payment of self-Contributions. However, the deferral period must be at least six months.
Exceptions to Minimum Deferral Period Rule
- If the deferral is for the purpose of resuming employment as a bargaining unit member with an Employer that contributes for an MCTWF Actives Plan benefit package-benefits, the minimum deferral period will be waived.
- If the retired individual asserts to the Fund that he is seeking to defer because he has coverage under another group health plan, he may resume MCTWF Retirees Plan participation any time thereafter, upon the Fund’s acknowledgement of receipt of written notification from the other group health plan that adequately evidences the retired individual’s loss of coverage.

2.3(i) WHEN COVERAGE BEGINS

Generally, coverage begins when eligibility has been confirmed and self-Contributions have been made. Once initial self-Contributions are received, the Retiree and eligible Spouse will be issued a new MCTWF Networks identification card and a Blue Cross ID Card, both of which will be in the name of the Retiree. These cards should be presented to all service providers to ensure appropriate coverage and to provide billing instructions. An SPD plus updated notifications, Summary of Benefits and Coverage and a full Schedule of Benefits also will be issued.

2.3(j) COVERAGE FOR RETIREE SPOUSES

Coverage automatically is provided to the Retiree Spouse of a newly enrolled Retiree if she is under age 65 and not eligible for Medicare.

If the Retiree marries after enrolling for coverage under a MCTWF Retirees Plan benefit package, an appropriate copy of the marriage certificate must be received by the Fund within 60 days of the date of marriage in order to provide coverage to the new Spouse retroactive to the date of marriage. If received thereafter, coverage for the Spouse will run from the date of the Fund’s receipt.

If the Retiree reaches age 65, or otherwise is eligible for Medicare, the Retiree’s eligible Spouse who is not yet age 65 or not otherwise eligible for Medicare may continue to participate at the Retiree’s self- Contribution rate for the earlier of eight Years following the date that the Retiree’s participation commenced or until she attains age 65 or is eligible for Medicare. Deferral periods extend the eight Years accordingly.

If the Retiree is eligible for Medicare before age 65, or dies and You are eligible for Medicare before age 65 or die prior to reaching age 65, the eligible Retiree Spouse who is not yet age 65 and not eligible for Medicare may continue participation at the Retiree self- Contribution rate until the later of the Retiree’s 65th birthday or eight years following the date that the Retiree’s participation commenced. Deferral periods extend the eight Years accordingly.

In the event that the Retiree Spouse exhausts her right to continue participation at the self- Contribution rate, the Retiree Spouse may continue participation as an Extended Retiree Spouse at the cost-based self- Contribution rates (reviewed annually and adjusted each Plan Year by the Trustees), until she reaches age 65 or, if earlier, she becomes eligible for Medicare.

If on the date of the MCTWF Actives Plan Participant’s death, he would have been able to satisfy the MCTWF Retirees Plan’s age and Years of service participation requirements, his Spouse may enroll in the MCTWF Retirees Plan in the same manner as prescribed for a retiring individual.
2.3(k) TERMINATION OF RETIREES PLAN ELIGIBILITY

The Retiree or his Spouse may lose their benefit coverage under the MCTWF Retirees Plan if the Retiree or his Spouse do not make the required self-Contributions, or the required self-Contributions are not made timely, or if the Trustees of the Fund, amend or terminate the MCTWF Retirees Plan.

Participation will end on the first Day of the following dates:
- the date the Retiree first become eligible for Medicare coverage, whether or not he enrolls in Medicare coverage. However, if Retiree’s Medicare eligibility is due to End Stage Renal Disease (ESRD), federal law requires that MCTWF’s Retirees Plan coverage remain primary to Medicare for 30 months, starting with the first month the Retiree became eligible to receive Medicare. Upon expiration of the 30-month period, MCTWF Retirees Plan participation ceases;
- the date of the Retiree’s death;
- the date the Retiree becomes eligible for coverage under an MCTWF Actives Plan benefit package;
- the date the Retiree engages in Prohibited Employment;
- the date the Fund fails to receive the required self-Contribution when due; or
- the effective date of (1) termination of MCTWF Retirees Plan or (2) amendment to the MCTWF Retirees Plan that causes the Retiree to no longer be eligible for coverage.

If the Retiree engages in Prohibited Employment he will not be eligible for future participation in the MCTWF Retirees Plan.

Except as otherwise noted, all references above to “Medicare” include both early age (Disability) and normal age Medicare Part A coverage. All references above to attaining age 65 refer to the last day of the month preceding the month in which the 65th birthday falls. In such cases where age 65 has been reached, but eligibility for Medicare has not been established, eligibility for coverage will continue under MCTWF’s Retirees Plan until such time as Medicare eligibility has been established.

Eligibility for MCTWF Retirees Plan coverage ceases once eligibility for Medicare Part A coverage commences. This rule applies separately to the Retiree and the Retiree’s Spouse. In addition to turning age 65, Medicare coverage is provided automatically following 24 months of Social Security Disability benefits and, in the case of Amyotrophic Lateral Sclerosis, the first month that Social Security Disability benefits begin. The Fund will seek recovery directly from the Retiree and the Retiree’s Spouse for benefits paid as the result of their failure to provide the Fund with advance notification of Medicare eligibility.

2.3(l) TERMINATION OF RETIREES SPOUSE PARTICIPATION ENDS

The Retiree Spouse’s participation will end on the first of the following dates:
- the date the Retiree Spouse first become eligible for Medicare coverage, whether or not she enrolls in Medicare coverage. However, if the Retiree Spouse’s Medicare eligibility is due to End Stage Renal Disease (ESRD), federal law requires that MCTWF’s Retirees Plan coverage remains primary to Medicare for 30 months, starting with the first month the Retiree Spouse became eligible to receive Medicare. Upon expiration of the 30-month period, MCTWF Retirees Plan participation ceases;
- the date of the Retiree Spouse’s death;
- the date the Retiree Spouse becomes eligible for coverage under an MCTWF Actives Plan benefit package;
- the date of the Retiree engages in Prohibited Employment;
• the date the Fund fails to receive the self-Contribution when due;
• the date the Retiree and Retiree Spouse divorce;
• the date the Retiree Spouse remarries after the Retiree’s death; or
• the effective date of (1) termination of MCTWF’s Retirees Plan or (2) an amendment to MCTWF’s Retirees Plan that causes the Retiree to be eligible for coverage.

Except as otherwise noted, all references above to “Medicare” include both early age (Disability) and normal age Medicare Part A coverage. All references above to attaining age 65 refer to the last day of the month preceding the month in which the 65th birthday falls. In such cases where age 65 has been reached, but eligibility for Medicare has not been established, eligibility for coverage will continue under MCTWF’s Retirees Plan until such time as Medicare eligibility has been established.

Eligibility for MCTWF Retirees Plan coverage ceases once eligibility for Medicare Part A coverage commences. This rule applies separately to the Retiree and the Retiree’s Spouse. In addition to turning age 65, Medicare coverage is provided automatically following 24 months of Social Security Disability benefits and, in the case of Amyotrophic Lateral Sclerosis, the first month that Social Security Disability benefits begin. The Fund will seek recovery directly from the Retiree and the Retiree’s Spouse for benefits paid as the result of their failure to provide the Fund with advance notification of Medicare eligibility.

The Retirees failure to notify the Fund of his divorce, or the death of his Spouse or his Spouse’s eligibility for early Medicare eligibility, immediately following the occurrence by phone followed by written notification, will result in the pursuit for recovery from the Retiree, and where applicable from the Spouse, the value of benefits paid on behalf of the Spouse after such event occurred. Untimely notification of divorce also may result in the unavailability of COBRA continuation coverage for the Spouse.

2.3(m) RECOGNITION OF OTHER FUND PARTICIPATION - RECIPROCITY

For retired individuals whose participation in a qualifying MCTWF Actives Plan benefit package commenced prior to November 30, 2003, credit for prior self-Contributions will be granted for participation in a Central States, Southeast and Southwest Areas Health and Welfare Fund (Central States) medical benefit package that included a component for coverage under the Central States Retiree Benefit Plan. This credit will be used, if necessary, for calculation of Years of service to determine whether the retired individual has met the initial eligibility requirements for MCTWF Retirees Plan participation. Such additional Years of service will be considered in establishing the retired individual’s required self-Contributions rate.

2.3(n) RETIREES DEATH BENEFITS

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

• be enrolled in the MCTWF Retirees Plan; and
• file a completed application for enrollment by the later of 90 Days after his MCTWF Retirees Plan Retirement Date or 30 Days after the date of the Fund’s letter approving the application for enrollment in the MCTWF Retirees Plan.

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

• be enrolled in the MCTWF Retirees Plan; and
• file a completed application for enrollment by the later of 90 Days after the Retiree’s MCTWF Retirees Plan Retirement Date or 30 Days after the date of MCTWF’s letter...
approving the application for enrollment in the MCTWF Retirees Plan.

Special Circumstances:

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

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

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

Enrolling

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

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

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

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

Contributions

Quarterly Contributions under the Retirees Death Benefit will be based on the individual's (Retiree or Spouse) age at the time of the Retiree's initial participation in the MCTWF Retirees Plan. The first Contribution for a three-month period (quarter) must be filed with the Fund along with the completed Retirees Death Benefit Election Form. Thereafter, Contributions must be paid for each successive quarter and must be filed with the Fund on or before the 20th day of the month preceding the quarter for which payment is due. Upon receiving a quarterly Contribution, the Fund will send a statement to the Retiree and/or Spouse for the following quarter. Contributions will not be accepted beyond the current quarterly Contribution period due. All Contributions received must include the social security number of each eligible Participant.
Failure by the Fund to provide a statement for quarterly Contributions does not relieve a Retiree or Spouse from the obligation to make timely Contributions. It is the responsibility of each Retiree and/or Spouse to send timely payments to the Fund. Coverage under the Retirees Death Benefit will terminate if Contributions are not filed with the Fund within the time required. Late Contributions will be accepted if payment for the quarter past due is received by the 15th of the month following the quarter due, together with a $50 late fee. Participants who have not made payment by the last business day of the quarter for which a payment is due will be sent a late notice reflecting the above. If the required payments are not received by the 15th of the month following the quarter due, coverage will be terminated, regardless of the reason (including non-receipt of the late notice). There will be no reinstatement of coverage under the Retirees Death Benefit following termination.

Contributions are non-refundable upon the termination of coverage under the Retirees Death Benefit. Furthermore, Contributions attributable to unexpired portions of a quarter are not refundable upon the termination of coverage under the Retirees Death Benefit.
Medical benefits under the MCTWF Actives Plan and MCTWF Retirees Plan may be subject to Deductible, Copayment and Coinsurance amounts. Each of these terms are defined in the glossary at the end of this Booklet. The MCTWF Actives Plan and MCTWF Retirees Plan may also provide for limits on your Annual exposure to Coinsurance amounts (i.e., an Out-of-Pocket Maximum).

Generally, if your Employer bargains out of one MCTWF Actives Plan into another, or You change Employers and consequently change MCTWF Actives Plans, all accrued Annual Deductible and Coinsurance amounts will be transferred to the new MCTWF Actives Plan.

Please refer to your Schedule of Benefits to determine what benefits are Covered under your MCTWF Actives Plan or MCTWF Retirees Plan and how they are paid.

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

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

You may choose to use Hospitals or health care providers that are not in the Network, or Out-of-Network providers. Because the 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. However, before services are rendered, insist that the provider submit the claim for payment to the local Blue Cross plan as the Fund utilizes a team of claims settlement experts who work to negotiate the cost of the claim on your behalf to achieve the deepest discount available. If You paid for services rendered prior to receiving them, pay close attention to your Explanation of Benefits provided by the Fund. The Fund may have obtained a discounted rate under the negotiation service. If the allowable benefit on the explanation of benefits is less than what You paid for services provided, contact your provider to discuss any monies that You have paid above the allowable rate.

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

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

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

All medical claims for services rendered by non-Blue Cross Blue Shield participating providers are referred by the Fund to Consilium, an expert bill negotiation vendor, with the goal of eliminating balance billing to You by the provider through Consilium’s negotiation of a settlement with it. If Consilium the negotiation vendor is unsuccessful, it determines whether the provider belongs to one or more of 150 provider networks and therefore subject to contractual limits on its charges. If either approach is successful, your financial responsibility only will be for the payment of your required deductible and or coinsurance charge. However, since Consilium’s negotiation is likely to result in lower payment to the provider (and therefore a lower coinsurance charge to You) than would a network contractually based amount, and since Consilium the negotiation vendor negotiates a bill that You have already paid, we urge You to resist the provider’s request that You pay the bill when the services are provided. Inform the provider that your benefit plan provides coverage even though the provider does not participate with Blue Cross Blue Shield and that it should submit a claim for payment to the local Blue Cross Blue Shield participating plan and bill You later if there is an amount still owed.

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

The Fund is required to furnish You upon request and without charge, a list of its Network of Physicians and other health care providers. This listing is referred to as the participating provider directory. You may also visit the Fund’s website to link to the BCBS PPO Network website to obtain up-to-date lists of Network Hospitals and health care providers.

3.1(a) WORLDWIDE NETWORK PROVIDERS
BlueCard Worldwide, gives You access to medical care when You are outside of the United States. For non-emergency inpatient medical care, You must call the BlueCard Worldwide service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177. The service center is staffed with multilingual representatives and is available 24 hours a day, seven days a week. By making arrangements through the service center your medical services will be Covered at in-network benefit levels. If You need emergency medical care, You may seek reimbursement by completing a BCBS International Claim Form and sending it to the BlueCard Worldwide service center. Reimbursement will be subject to Copayments and other emergency service limits (see Sec. 3.14, Emergency Services).

3.1(b) CERTAIN OUT-OF-NETWORK PROVIDER SERVICES COVERED AT IN-NETWORK LEVELS
The below listed provider categories do not participate in the BCBS PPO Network, but do participate in the BCBS Traditional Network. Services obtained from BCBS Traditional Network providers in the following categories will be Covered at in-network benefit levels:

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

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

3.2(a) MEDICAL CARE

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

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

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

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

3.2(a) NON-ACCESS EXEMPTION APPLICATION

Your Application must be received by the Fund within 60 Days following the date of receipt of Out-of-Network services. The claim will be deemed as Out-of-Network and all applicable Deductible, Co-payment and Coinsurance amounts will apply. The approval will continue for six months from the date that the first Out-of-Network services are rendered. Any services beyond the six month period must be authorized pursuant to the submission and approval of your new application. You may obtain the Fund Exemption Application form, by calling MCTWF’s Member Services Call Center or from the Fund’s website.

SEC. 3.3: USING YOUR IDENTIFICATION CARDS

You should present your MCTWF Networks Card and your Blue Cross ID card at the time You receive medical services. Only your MCTWF Networks Card is necessary to receive services at participating pharmacies.
When You present your card for medical services, claims for the services will be sent directly to the local Blue Cross Blue Shield Plan for processing by the provider (see Sec. 13.1, Claims for Medical Benefits - Actives and Retirees, for information about filing claims for medical benefits).

**SEC. 3.4: SCHEDULE OF BENEFITS**

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

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

3.5(a) ALLOWED AMOUNTS

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

3.5(b) DEDUCTIBLE

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

3.5(c) COINSURANCE

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

3.5(d) COPAYMENT

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

3.5(e) OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum shown in your Schedule of Benefits for specific medical benefit packages limits the amount of money that You will have to spend for Coinsurance charges during each calendar year. Additionally, the Affordable Care Act provides for required calendar year in-network, medical and prescription drug combined out-of-pocket cost limits for individuals and families as also shown in your Schedule of Benefits.

3.5(f) MAXIMUM ALLOWABLE BENEFIT

Maximum Allowable Benefit means your MCTWF Actives Plan or MCTWF Retirees Plan’s allowable portion of the Amount Billed by a provider that does not participate in the BCBS, Davis Vision or Delta Dental of Michigan networks, subject to Deductible, Copayment and Coinsurance amounts.
SEC. 3.6: PRIOR AUTHORIZATION

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

- applied behavioral analysis (ABA);
- bariatric surgery;
- blepharoplasty and ptosis repair; upper lid;
- breast reduction mammoplasty;
- breast reconstruction;
- colonoscopy screening (except those that meet the wellness benefit criteria);
- developmental speech therapy;
- Durable Medical Equipment-purchase;
- echocardiography services;
- gastric electrical stimulation therapy
- growth hormone stimulation;
- home health care;
- hospice;
- human organ transplants;
- blepharoplasty and ptosis repair; upper lid;
- in-lab sleep testing;
- inpatient mental health and substance use disorder treatment;
- inpatient hospital medical admission;
- PET scans;
- CT scans;
- Skilled Nursing Facility care; and
- nuclear cardiology.

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

SEC. 3.7: HOSPITAL

3.7 (a) ROOM AND BOARD

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

The MCTWF Actives Plan and MCTWF Retirees Plan pays for other Hospital services provided by the Hospital, Hospital staff member or prescribed by your Doctor while You are confined as an inpatient and include but are not limited to:

• treatment in special care units such as burn, cardiac or intensive care;
• general nursing services;
• operating, delivery and treatment rooms and equipment;
• anesthesia;
• laboratory examinations;
• physical therapy;
• oxygen and other gas therapy;
• drugs and medicines;
• supplies for dressings and plaster casts;
• use of radium, when owned and operated by the Hospital;
• prescription drug infusion therapy (for a course of treatment) and intravenous therapy (for one dose of treatment); and
• dialysis.

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

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

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

SEC. 3.8: SURGICAL

The MCTWF Actives Plan and MCTWF Retirees Plan pays for surgical services.

SEC. 3.9: SECOND AND THIRD MEDICAL OPINIONS

The MCTWF Actives Plan and MCTWF Retirees Plan pays up to the Maximum Allowable Benefit charge for a second and third opinion (including diagnostic lab tests and diagnostic imaging) regarding a previously recommended medical treatment or surgical procedure, even if You choose not to follow the Doctor's advice. In order to receive these benefits, the Doctor must include the appropriate code to indicate that the charges are for a second or third opinion.
SEC. 3.10: DIAGNOSTIC IMAGING
The MCTWF Actives Plan and MCTWF Retirees Plan pays for diagnostic imaging services.

SEC. 3.11: LABORATORY TESTS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for laboratory tests.

SEC. 3.12: PHYSICIAN VISITS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for Physician’s office visits and in-Hospital Physician visits.

SEC. 3.13: SKILLED NURSING FACILITY
The MCTWF Actives Plan and MCTWF Retirees Plan pays for room and board and other medical services if You are transferred to a Skilled Nursing Facility care immediately following a Hospital stay. Your provider must obtain prior authorization for Skilled Nursing Facility care (see Sec. 3.6, Prior Authorization, for instructions).

SEC. 3.14: EMERGENCY SERVICES
The MCTWF Actives Plan and MCTWF Retirees Plan pays for emergency room treatment for emergency Accidental Injuries and emergency Injury or Illnesses. The MCTWF Actives Plan and MCTWF Retirees Plan will hold You harmless from balance billing when no Network choice is reasonably available, until the acute emergency phase is resolved. In the event that You are admitted directly into the Hospital, the emergency room Copayment is waived and only the Hospital admission Copayment applies.

An emergency is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm. Some examples of such emergency Illnesses are heart attack, strokes, loss of conscientiousness and convulsion. Some examples of emergency Accidental Injuries are severe eye or head injury, medication overdose, poison ingestion, severe allergic reaction, animal bite, burn, smoke inhalation, and frostbite.

In general, emergency room treatment for medical conditions that do not require immediate attention (to prevent death or serious bodily harm), including chronic medical problems, is not covered as a benefit. However, the Fund has made arrangements with Blue Cross Blue Shield of Michigan that will avail members of BCBS discounts. The Fund will “approve” emergency room facility claims and emergency room physician claims for treatment of non-emergent conditions, thereby triggering the BCBS discounts. The Fund will continue not to pay any portion of the non-emergent emergency room facility claims, but will make payment toward the non-emergent emergency room physician claims in an amount approximately equivalent to what the Fund would have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by the Fund’s payment at the urgent care rate for those services.
For conditions that require medical attention and cannot wait for an appointment with your physician, but are not “emergent,” treatment should be sought from an urgent care center. All emergency room claims incurred by individuals in excess of three per 12 month period are reviewed by the Fund’s Medical Director for medical necessity. Should the use of the emergency room be determined to not have been medically necessary, You will be responsible for payment as noted above.

**SEC. 3.15: AMBULANCE SERVICES**

The MCTWF Actives Plan and MCTWF Retirees Plan pays for eligible expenses reimbursed for ground, air or water ambulance services for basic and advanced life support and transportation to a medical facility for treatment of a medical emergency, or from one Hospital facility to another for reasons of medical necessity. Transfer from one Hospital facility to another and back, to receive treatment recommended by a Doctor but not available at the facility of origin, is also Covered. Due to the emergent nature of these services, such services provided by Out-of-Network providers are treated as in-network with respect to Deductible, Copayment and Coinsurance amounts. You will be held harmless from out-of-network balance billing exposure when, in seeking emergency ambulance services You receive services from a non-participating ambulance provider, when no other reasonable choice is available.

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

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

- the use of an air ambulance is Medically Necessary and ordered by a Physician;
- the physician must have a reasonable expectation of significant time savings by the use of air ambulance transport as compared to ground or water ambulance transport time and that such time savings will reduce the risk of loss of life, limb or bodily function;
- You are transported to the nearest medical facility capable of treating the patient's condition; and
- the provider is a licensed air ambulance service, not a commercial air carrier.

**SEC. 3.16: MATERNITY**

The MCTWF Actives Plan and MCTWF Retirees Plan pays for pre-natal care, post-natal care and obstetrical services.

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

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

### 3.16 (a) MIDWIFE SERVICES

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

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

### SEC. 3.17: HOME HEALTH CARE

Receiving care in your home is often more desirable than remaining in the Hospital. The MCTWF Actives Plan and MCTWF Retirees Plan pays for home health care services for You if -

- You are homebound or normally unable to leave home unassisted;
- the treating Physician recommends home health care and it is prescribed under a home health care treatment plan; and
- You require intermittent skilled nursing care, physical therapy, speech-language pathology services or continued occupational therapy.

The MCTWF Actives Plan and MCTWF Retirees Plan pays for home health care services, provided that You have received prior authorization from the Fund (see Sec. 3.6, Prior Authorization, for instructions).

### 3.17 (a) NURSING CARE

The MCTWF Actives Plan and MCTWF Retirees 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 the Fund’s prior authorization as part of the home health care benefit.

Services of home health care nurses are limited as follows:

- Daily home health care visits are limited to the number of visits approved by the Fund as necessary for a particular course of treatment; and
- Up to 24 hours of care per day for 5 Days lifetime maximum, up to 16 hours of care per day for 45 Days lifetime maximum and up to 8 hours of care per day for 900 Days lifetime maximum.
**SEC. 3.18: HOSPICE**

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

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

**SEC. 3.19: RESPITE CARE**

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

**SEC. 3.20: CHIROPRACTIC SERVICES**

The MCTWF Actives Plan and MCTWF Retirees Plan pays for 24 spinal manipulations per person Annually, one mechanical traction per day (only with spinal manipulation), one new patient office visit every 36 months and one established patient office visit Annually, per chiropractor. The chiropractic services for those diagnoses deemed by BCBSM as treatable with chiropractic services are as follows:

- Nonallopathic lesions -
  - cervical region;
  - head region;
  - lumbar region;
  - sacral region; and
  - thoracic region.

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

Non-surgical spinal decompression therapy services rendered will be subject to Out-of-Network Deductible, Copayment and Coinsurance amounts. Effective with service dates January 1, 2016 and after, non-surgical spinal decompression therapy is not a covered benefit.

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

The MCTWF Actives Plan and MCTWF Retirees Plan pays for eligible expenses for services rendered by and ophthalmologist or optometrist within their licensed scope of treatment and the Fund’s medical necessity criteria.
SEC. 3.22: HEARING

The MCTWF Actives Plan and MCTWF Retirees health and supplemental benefits package pays a hearing benefit once every two years. The benefit is a scheduled amount which includes -

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

3.22 (a) COVERED HEARING AID ITEMS

Hearing aids that are Covered by the MCTWF Actives Plan and MCTWF Retirees health and supplemental benefits package are -

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

3.22 (b) AID ITEMS NOT COVERED

The MCTWF Actives Plan and MCTWF Retirees Plan does not pay for the following items related to hearing aids:

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

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

SEC. 3.23: DURABLE MEDICAL EQUIPMENT (DME)

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

A full list of Covered DME equipment can be found on the Schedule of Benefits page of the Fund’s website.
The following types of equipment are not considered DME and are examples of non-Covered items:
- comfort or convenience items;
- exercise and hygienic equipment;
- Physician’s equipment;
- self-help devices;
- spare equipment; and
- disposable equipment.

SEC. 3.24: MEDICAL SUPPLIES
The MCTWF Actives Plan and MCTWF Retirees Plan pays for medical supplies. Medical supplies are supply items that are generally disposable, non-durable and Medically Necessary. All medical supplies must be prescribed and certified as Medically Necessary by a licensed Physician, and obtained from a provider whom Blue Cross Blue Shield (BCBS) has certified as a medical supplies provider. Medical supplies include lancets, test strips, masks, hoses, dressings, intra-uterine devices (IUD) with the insertion and removal Covered under the surgical portion of the MCTWF Actives Plan and MCTWF Retirees Plan, etc., of which some have quantity limits. Comfort and convenience items are not considered medical supplies and are not Covered. A full list of Covered medical supplies can be found on the Schedule of Benefits page of the Fund’s website.

To determine whether a specific DME or medical supply item is a Covered item, or to determine whether a provider is a BCBS certified supplier, You may contact the Fund's Member Services Call Center or access it from the Fund's website. While the list does not contain quantity limits, all BCBS certified suppliers are aware of these restrictions.

SEC. 3.25: WELLNESS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for periodic health examinations and services. Applicable Deductible, Copayment and Coinsurance amounts for services rendered by Network providers will be waived. Services rendered by Out-of-Network providers will be subject to Out-of-Network Deductible, Copayment and Coinsurance amounts, as well as balance billing.

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

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

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

**SEC. 3.26: OTHER MEDICAL BENEFITS**

**3.26(a) APPLIED BEHAVIOR ANALYSIS**

The MCTWF Actives Plan pays for Applied Behavior Analysis (ABA) services under the following conditions for dependent children through age 18 diagnosed with an autism spectrum disorder.

Applied behavior analysis services are subject to the following hour limits based on the patient’s age on January 1st of each year:
• 1,300 hours limit through age 6 (subject to service limitations below)
• 1,040 hours limit through age 12 (subject to service limitations below)
• 780 hours limit through age 18 (subject to service limitations below)

Effective with service dates of January 1, 2016 and after, all limits on the Fund’s ABA coverage for autism spectrum disorders are eliminated.

The requirements which must be satisfied for coverage of ABA services are as follows:
• Services in Michigan – An approved Blue Cross Blue Shield of Michigan (BCBSM) autism evaluation center must make or confirm the autism spectrum disorder diagnosis and provide a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services, before treatment begins. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the
treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst may be non-participating but must be registered with BCBSM. A link to Approved Autism Evaluation Centers and Board-Certified Behavior Analysts is available on the Info Links page of the Fund’s website.

- Services Outside of Michigan – The participant must obtain a multidisciplinary evaluation from an academic medical center or a hospital based facility (participating with the Blue Cross Blue Shield plan in the state where services will be provided) that makes or confirms the autism spectrum disorder diagnosis and provides a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst must be a participating provider in the Blue Cross plan in the state where services will be provided. A link to Blue Cross Blue Shield Non-Michigan Physician, Hospital and Urgent Care Searches is available on the Provider Networks page of the Fund’s website.

### ABA Services

<table>
<thead>
<tr>
<th>Initial Assessment</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reassessment</td>
<td>No limitation</td>
</tr>
<tr>
<td>Line Therapy</td>
<td>Limited to 25 hours per patient per 7 days (Sunday-Saturday)</td>
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<tr>
<td>in combination with skills training services</td>
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<tr>
<td>Skills Training</td>
<td>Limited to 25 hours per patient per 7 days (Sunday-Saturday)</td>
</tr>
<tr>
<td>in combination with line therapy services</td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td>Limited to 3 hours per patient per 7 days (Sunday-Saturday)</td>
</tr>
<tr>
<td>Caregiver Training</td>
<td>Limited to 3 hours per patient per 7 days (Sunday-Saturday)</td>
</tr>
</tbody>
</table>

Effective with service dates of January 1, 2016 and after, all limits on ABA coverage for autism spectrum disorders are eliminated.

### 3.26(b) BARIATRIC SURGERY

The MCTWF Actives Plan and MCTWF Retirees Plan pays for bariatric surgery (gastric surgery for morbid obesity) in all medical plans for those between the ages of 18 and 60. The same is true for patients below age 18 if satisfactory documentation is presented that appropriate consideration has been given to the risk of surgery on future growth, the patient’s maturity level and ability to understand the surgical procedure and to comply with post-operative instructions, and the adequacy of family support. The same also is true for patients above age 60 if satisfactory documentation is presented that based on the patient’s physiologic age and co-morbid conditions, a positive risk/benefit ratio exists. The general prior authorization criteria are as follows:

- The patient has a body mass index (BMI) of 40 or greater. If the patient’s BMI is between 35 and 39, authorization will be granted if one or more co-morbid conditions also exist, including but not limited to:
  - degenerative joint disease (including degenerative disc disease)
  - hypertension
  - hyperlipidemia or coronary artery disease
  - other atherosclerotic diseases
  - type II diabetes mellitus
  - sleep apnea
  - congestive heart failure.
PART 3: MEDICAL BENEFITS - MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

• The patient has been clinically evaluated by a physician (or authorized delegate) and the physician has documented the failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of six consecutive months within the last four years prior to the recommendation for bariatric surgery. However, this requirement is waived for super morbidly obese individuals (i.e., those who have a BMI of 50 or greater). Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated.

• Documentation has been provided demonstrating that the physician and the patient have a good understanding of the risks involved and that the physician has a reasonable expectation that the patient will be compliant with all post-surgical requirements.

• The patient has had a psychological evaluation performed as a pre-surgical assessment by a mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of the surgery and to give informed consent, and ability to cope with expected post-surgical lifestyle.

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

3.26(c) BREAST RECONSTRUCTION

If you have a mastectomy, the MCTWF Actives Plan and MCTWF Retirees Plan pays for the following:
• reconstruction of the breast on which the mastectomy was performed;
• surgery and reconstruction of the other breast to produce a symmetrical appearance;
• prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas; and
• a maximum of four mastectomy bras per calendar year.

3.26(d) BREAST REDUCTION MAMMOPLASTY

The MCTWF Actives Plan and MCTWF Retirees Plan pays for breast reduction mammoplasty which requires prior authorization by satisfying the following requirements:

• The patient must be old enough to ensure that her breasts are fully developed.

• The amount of tissue to be removed must be greater than or equal to the 22nd percentile on the Schnur Sliding Scale.

• Two of the below requirements must be met:
  - Documented pain in the neck and/or shoulders, or postural backache, which must be of long-standing duration. Failure of conservative therapy, including an appropriate support bra, exercises, heat/cold treatments and appropriate non-steroidal anti-inflammatory agents or muscle relaxants.
  - Shoulder grooving.
  - Recurrent intertrigo between the breasts and the chest wall that has not responded to dermatologic treatment.

To obtain prior authorization the provider must contact the Fund’s Utilization Review Department (see Sec. 3.6, Prior Authorization, for instructions). If services are performed without prior authorization, You may be fully responsible for payment of the provider’s charges.
3.26(e) CARDIAC REHABILITATION

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

- may be provided by the outpatient portion of a Hospital or under the supervised direction of a Physician;
- the facility has available for immediate use all the necessary cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as Medically Necessary, e.g., oxygen, CPR equipment or defibrillator;
- the program is conducted in an area set aside for the exclusive use of the program while it is in session;
- phase two cardiac rehab services (where rehab from losses that occurred prior to or during hospitalization are corrected) are for one of the following cardiac conditions:
  - acute myocardial infarction;
  - coronary artery bypass;
  - chronic stable angina pectoris;
  - percutaneous transluminal coronary angioplasty;
  - heart valve surgery;
  - heart transplant;
  - class III or IV congestive heart failure unresponsive to medical therapy;
- You must have a clear medical need for the services prescribed by the attending Physician; or
- the program must begin within 90 Days of a cardiac event and be completed within six months.

3.26(f) CHEMOTHERAPY AND RADIATION THERAPY

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

3.26(g) COLONOSCOPY SCREENING

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

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

3.26(h) CONTRACEPTIVE MANAGEMENT

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

3.26(i) DENTIST AND DENTAL SURGEON SERVICES

The MCTWF Actives Plan and MCTWF Retirees Plan pays for services secondary to dental coverage for repair of natural teeth as the direct result of an Accidental Injury or caused by congenital or genetic abnormalities. In either case allowed charges first are applied against available dental limits before being covered under your medical benefits.

3.26(j) DEVELOPMENTAL SPEECH THERAPY

The MCTWF Actives Plan pays for unlimited therapy designed to restore and maintain speech function (restorative speech therapy). Effective with dates of service on or after November 5, 2015, the Fund benefits include coverage designed to develop and maintain the dependent child’s speech function (developmental speech therapy) when the services provided by the dependent child’s school district are deemed by the Fund to be inadequate to meet the dependent child’s reasonable needs.

In order to be eligible for developmental speech therapy, such services must be prior authorized annually by the Fund’s Utilization Review Department, subject to review of the dependent child’s current Individualized Education Plan and a letter of medical necessity from the referring physician must be provided to the Fund.

Approved developmental speech therapy is paid subject to the same benefit level as the restorative speech therapy benefit with a maximum of 30 visits each calendar year and only until the last day of the month in which the dependent child turns 18 years old.

3.26(k) DIALYSIS

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

3.26 (l) DIETARY COUNSELING

The MCTWF Actives Plan and MCTWF Retirees Plan pays for unlimited dietary counseling by a certified dietician for certain diagnostic categories. To obtain a list of Covered categories contact the Fund’s Member Services Call Center.
3.26 (m) ECHOCARDIOGRAPHY SERVICES
The MCTWF Actives Plan and MCTWF Retirees Plan pays for expansion of its current radiology management program by requiring prior authorization of non-emergency outpatient echocardiography services performed in a physician’s office, freestanding radiology center, or hospital outpatient setting (but not in the inpatient, observation, or emergency room setting). Michigan providers must obtain prior authorization by contacting AIM Specialty Health (see Important Phone Numbers). Non-Michigan providers must obtain prior authorization by contacting the Fund’s Utilization Review department (see Important Phone Numbers). If services are performed, but not prior authorized, the participant may be responsible for full payment of charges.

3.26(n) EXPERIMENTAL, INVESTIGATIVE OR OTHERWISE NOT REASONABLE OR CUSTOMARY TREATMENT
The MCTWF Actives Plan and MCTWF Retirees Plan pays for Medically Necessary services to correct complications arising out of Experimental, Investigative or otherwise not reasonable or customary treatment.

3.26(o) GASTRIC ELECTRICAL STIMULATION THERAPY
Gastric Electrical Stimulation (GES) Therapy is a treatment option for those who suffer with chronic nausea and vomiting associated with gastroparesis, a common gastrointestinal motility disorder. This most commonly occurs in diabetic patients and may require frequent hospitalization due to hypoglycemia or hyperglycemia, electrolyte imbalance or other complications of this disease.

The MCTWF Actives Plan and MCTWF Retirees Plan pays for GES Therapy for participants suffering from both diabetes and gastroparesis. Physicians must obtain prior authorization by contacting the Fund’s Utilization Review Department (see Important Phone Numbers). If services are performed, but not prior authorized, the participant may be responsible for full payment of charges.

3.26(p) HYPERALIMENTATION (TPN)
The MCTWF Actives Plan and MCTWF Retirees Plan pays for hyperalimentation and services and supplies necessary for the administration of hyperalimentation as part of a home health care treatment program.

3.26(q) INFUSION THERAPY
The MCTWF Actives Plan and MCTWF Retirees pays for infusion therapy services for a course of treatment.

3.26(r) INJECTIONS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for injections (e.g., allergy, antibiotic, contraceptive), when administered to treat a medical condition.
3.26(s) IMMUNIZATIONS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for adult immunizations as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

3.26(t) INTRA-ARTICULAR INJECTIONS
The MCTWF Actives Plan and MCTWF Retirees Plan pays for limited coverage for intra-articular injections of the knee for participants with the following conditions:
- osteoarthritis, localized, primary, lower leg;
- osteoarthritis, localized, secondary, lower leg; and
- osteoarthritis, localized, not specified whether generalized or localized, lower leg.

Individuals with osteoarthritis of the knee who have obtained insufficient pain relief from conservative non-pharmacological therapy (such as physical therapy) and simple analgesics, and have failed conservative therapy with non-steroid anti-inflammatory drug (NSAID), or who have contraindications to NSAID therapy, are eligible for a course of treatment with intra-articular cartilage injections of from one to five weekly injections once per three month period.

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

In addition to the exclusions listed in the General Exclusions and Limitations (see Part 1) and Medical Expenses Not Covered (see Sec. 3.32) sections of this Booklet, the following orthotic devices may be excluded as well:
- arch supports or supportive devices for the feet;
- orthotic devices used for participating in strenuous physical activity beyond normal activities or daily living;
- orthopedic or corrective shoes (except when either one of both are an integral part of a leg brace); or
- non-rigid applications such as elastic stockings, corsets or garter belts.

3.26(v) PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY
The MCTWF Actives Plan and MCTWF Retirees Plan pays for physical, occupational and speech therapy when You require therapy to restore and maintain normal function.

Note: Since for congenital type diagnoses, therapy is required to develop and maintain function rather than to restore and maintain function, it is not Covered under your MCTWF Actives Plan or MCTWF Retirees Plan.
**3.26(w) PROSTHETIC DEVICES**
The MCTWF Actives Plan and MCTWF Retirees Plan pays for prosthetic devices when prescribed by your Physician and obtained from a provider who Blue Cross Blue Shield (BCBS) has certified as a prosthetic device supplier.

**3.26(x) SLEEP STUDIES**
The MCTWF Actives Plan and MCTWF Retirees Plan pays for sleep studies for the following diagnoses:

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

The Fund requires that all Michigan providers obtain prior authorization for in-lab sleep testing for Fund members by contacting AIM Specialty Health (see Important Phone Numbers). All non-Michigan providers must obtain prior authorization for in-lab sleep testing for Fund members by contacting the Fund’s Utilization Review Department at (see Important Phone Numbers). To obtain prior authorization, the provider must justify why an in-lab sleep test is more clinically appropriate for the patient than a home sleep test. If services are performed, but not prior authorized, the member may be responsible for full payment of charges.

**3.26(y) SCLEROTHERAPY**
The MCTWF Actives Plan and MCTWF Retirees Plan pays for sclerotherapy services, limited to one injection per Day, up to a maximum of 10 injections per calendar year.

**3.26(z) SPECIAL FORMULAS AND MEDICAL FOODS- Actives Plan**
The MCTWF Actives Plan pays for special formulas and medical foods prescribed for infants and young children born with certain inherited metabolic diseases per the following:

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

**Medical foods** - Physician prescribed medical foods and solid, modified food supplements are Covered for children through age 18.

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

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

**3.26(aa) TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION**
The MCTWF Actives Plan and MCTWF Retirees Plan pays for services related to the diagnosis and medical treatment of temporomandibular joint dysfunction.
SEC. 3.27: MCTWF ACTIVES PLAN EXTENDED DISABILITY

Extended disability medical benefits may be available for MCTWF Actives Plan participants or Beneficiaries who became disabled while covered under a Fund benefit package and whose active coverage thereafter ceased. If eligible, extended disability coverage will be provided for medical and prescription drug benefits that were available during active coverage, but solely in connection with the disabling disability for a period up to the earlier of (a) 24 months, (b) the date the member becomes eligible for Medicare benefits or other group health coverage, or (c) the date the member is no longer totally disabled.

To qualify for extended disability medical benefits, ALL of the following conditions must be met:

• as determined by MCTWF Actives Plan Trustees, You were totally disabled when coverage ended and remain continuously disabled until the date the medical expense is incurred; and

• within fifteen months from the date your Active coverage ceased, documentation is provided to the Fund by the Physician verifying the total disability; and

• the treatment or services received after active coverage ceases within the following period: the earlier of (a) 24 months, (b) the date the member becomes eligible for Medicare benefits or other group health coverage, or (c) the date the member is no longer totally disabled; and

• The treatment or services must be for the same Accidental Injury or Illness that existed on the date the coverage ended and caused the total disability.

• For the first 90 days of the Extended Disability medical benefit period, the level of coverage is dependent upon whether the provider is in-network or out-of-network. For the last 21 months, coverage is limited to out-of-network levels of coverage regardless of whether the provider is network or out-of-network. Annual individual and family deductibles and coinsurances will apply based on the network affiliation and the specific MCTWF Actives Plan benefit package.

SEC. 3.28: HUMAN ORGAN TRANSPLANT

The MCTWF Actives Plan and MCTWF Retirees Plan pays for human organ transplant services. Phase I and Phase II transplant services are Covered as medical benefit expenses under your Plan, and Phase III services are Covered in full through the Blue Cross Blue Shield of Michigan’s Specified Organ Transplant Program (SOTP) and its nationwide network of transplant centers of excellence, the Blue Distinction Centers for Transplant (BDCT). All human organ transplants must be performed at a designated BDCT facility, a list of which can be obtained from the Provider Networks and Info Links pages of the Fund’s website, and require prior authorization. Should You require a transplant, your Doctor or Hospital should contact Blue Cross Blue Shield. You may also contact the Fund’s Member Services Call Center for assistance. Coverage is available only if the transplant is not considered Experimental in nature and all other eligibility provisions are satisfied.

The human organ transplant benefit includes heart, liver, single or bilateral lung, combination heart and bilateral lung, simultaneous pancreas/kidney and pancreas and combination liver/kidney transplants.

Kidney, cornea, bone marrow and skin transplants are not included in the human organ transplant benefit; these transplants are covered as medical/surgical expenses, and are subject to MCTWF Actives Plan and MCTWF Retirees Plan Deductible, Copayment and Coinsurance amounts.
3.28 (a) COVERED EXPENSES

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

Phase I – Pre-Transplant Evaluation. This phase covers health services that are required to evaluate You for acceptance into a transplant program, Covered as a medical benefit expense and subject to any limitations that are contained in your MCTWF Actives Plan or MCTWF Retirees Plan benefit package. Health services under Phase I covers inpatient health care, outpatient health care and services of health care professionals. Phase I includes health services related to testing, HLA typing and donor identification for living-related and unrelated kidney and allogeneic bone marrow transplants. It also includes the harvesting and storage of bone marrow tissue for autologous bone marrow transplants. Phase I ends and Phase II begins at the time it is determined that You are an appropriate candidate for a transplant.

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

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

Specified Organ Transplant Program

Phase III – Transplant and Post Transplant Procedures. This phase covers those health services required during the approved transplant from the hospital admission through the 12 month period following the transplant procedure. Health services under phase III include -

• facility and professional services
• copayment requirements for anti-rejection drugs and other transplant-related prescription drugs;
• coinsurance requirements for immunizations (as recommended by the Advisory Committee on Immunization Practices) against certain common infectious diseases during the first 24 months post-transplant;
• medically necessary services needed to treat a condition arising out of the organ transplant surgery if it occurs during the benefit period and is a direct result of the organ transplant surgery; and
• transportation and lodging (related to the transplant procedure only) up to a maximum of $10,000 for the transplant recipient (a) plus one person if the recipient is an adult or (b) plus two people if the recipient is a minor, or if the transplant involves a living-related donor. The coverage period for transportation and lodging begins five days prior to the transplant and ends when the recipient is discharged from the hospital and returns home.
Note: Additional approved transplants that You may require during phase III as a replacement of a previous transplant are considered a separate transplant.

After one year the transplant is considered successful and any further related services are Covered as medical/surgical expenses subject to MCTWF Actives Plan and MCTWF Retirees Plan Deductible, Copayment and Coinsurance amounts, with the exception of anti-rejection drugs which continue to be Covered in full (including any Copayment requirements under your MCTWF Actives Plan or MCTWF Retirees Plan benefit package) for as long as You are Covered under the MCTWF Actives Plan and MCTWF Retirees Plan.

Continuation of Transplant Benefits at Retirement. If You retire during any of the transplant service phases, including the start of Phase I, your transplant benefits will continue if You are eligible for MCTWF Retirees Plan benefits.

3.28(b) ORGAN TRANSPLANT DONOR COVERED EXPENSES

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

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

SEC. 3.29: MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

Blue Cross Blue Shield PPO is the Network provider of services for all Mental Health and Substance Use Disorder Treatment, both inpatient and outpatient. All mental health and substance use disorder treatment inpatient services (including admissions and services for programs administered in connection with inpatient hospitalizations for mental health treatment, with partial hospitalizations for mental health treatment, with inpatient residential treatment for substance use disorder treatment) require the patient to receive prior authorization through Blue Cross Blue Shield.

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

SEC. 3.30: TELEHEALTH SERVICES

The MCTWF Actives Plan and MCTWF Retirees Plan pays for a convenient service for treatment of many non-acute medical conditions. This service, known as a “telehealth” (or “telemedicine”) consultation, is provided by MDLIVE™. MDLIVE provides You with on-demand access to U.S. Board certified physicians and licensed therapists by secure video (between 7am and 9pm), or by phone or e-mail anytime and almost everywhere throughout the country. Your consultation generally will occur in less than 15 minutes from the time You request it. You also can choose a provider and schedule a consultation for a time that works best for You.
MDLIVE physicians are state licensed and Board certified and are credentialed in family practice, internal medicine, pediatrics, or emergency medicine. MDLIVE physicians average 15 years of experience. The goal is to connect You with the care You need, whenever You need it. Whether You are at home, at work, traveling, or You simply want the most convenient way to see a doctor, real-time video and phone consultations allow for the diagnosis and treatment of a wide range of medical conditions, regardless of your location, in a safe, secure and confidential environment.

Each consultation with a MDLIVE physician or behavioral health therapist will cost You $10, payable by debit or credit card. You can receive unlimited free e-mail advice. Prescriptions* are sent electronically to your chosen pharmacy and MDLIVE’s on-line patient portal provides You with a secure way to store and access your MDLIVE electronic personal health records.

* Prescriptions are issued only when clinically appropriate. No controlled substances may be prescribed and the availability of other prescriptions may be restricted by law.

When To Use MDLIVE
• If You are considering the ER or urgent care center for a non-emergency medical issue
• If your primary care physician is not available
• If You are traveling and in need of medical care
• During or after normal business hours, nights, weekends, and holidays

Common Conditions Treated
Medical
Allergies Asthma Bronchitis
Cold & Flu Constipation Diarrhea
Ear Aches Fever Headache
Infections Insect Bites Joint Aches & Pains
Nausea Pink Eye Rashes
Sore Throat

Behavioral Health
Child Behavior & Learning Concerns
Coping with Loss & Grief
Stresses & Challenges of Everyday Life

Before seeking your first phone or video consultation, You and your eligible family members will need to activate their account. Activation is easy and it will speed up the time it will take to arrange for your first consultation when You need it. You and your family can register by phone with the help of an MDLIVE health services specialist at 1-888-632-2738 or on-line at www.mdlive.com/mctwf, a link to which, as well as a guide for on-line activation, is available on the Info Links page of the Fund’s website.

When activating your account on-line -

1. The participant must activate their account before eligible family members can be activated. The participant must enter the last 4 digits of his social security number and his date of birth, continue to the next screen to select name from among his listed family members, and then continue to each of the patient sign-up screens, creating a username and a password and filling in other requested information.
2. An e-mail confirmation will be sent to the participant. Once received, the participant will complete the activation process by clicking on the activation link. Then he will be prompted to login using his username and password. This will take him to his personal portal’s “Dashboard.”

3. The participant now may register each dependent minor child in the same manner that he did for himself by selecting each name from the drop down next to the participant’s name in the upper right hand corner of the Dashboard screen. The participant’s spouse and children over age 18 may register by using the participant’s last 4 digits of his social security number and his date of birth and then following the above process for themselves.

4. Each registered person should fill out his medical history by clicking on the link, “My Health” on the left hand side of their Dashboard page and then completing all of the tabs under “My Health.”

5. Also to the right hand side of your Dashboard is the link, “You need to choose a pharmacy.” Each registered person should select the network pharmacy to which he wishes his prescriptions sent. MDLIVE physicians have been asked to observe the Fund’s prescription benefit rules and limitations apply when prescribing medications.

Requesting a medical or behavioral health consultation, by phone or on-line -
If arranging for a consultation on-line, sign in using the username and password You created to be directed to your Dashboard from where You can seek a phone consultation with the next available “on call” doctor or therapist available, or You can select from a number of family doctors, pediatricians, or therapists to schedule a phone or video consultation at a time that best fits your schedule (however, video consultations must occur between 7am and 9pm). For scheduled video consultations, sign in to the MDLIVE portal five minutes prior to your consultation. You will be prompted to update your health information and your pharmacy selection, and download “VSee”, MDLIVE’s proprietary secure video software; the provider will then connect with You. If You have any questions regarding “VSee” or regarding any other issue, contact MDLIVE Customer Services at 1-888-632-2738 and You will be assisted. Also available is an application that will permit video consultations using mobile devices such as iPhones, tablets or android devices. By going to mdlive.com/getapp You can get it for free.

Once your eligibility has been established You will receive by mail a welcome kit containing information about MDLIVE, an identification card and a key ring attachment stating MDLIVE’s phone number and URL.

SEC. 3.31: MEDICAL EXPENSES NOT COVERED
In addition to the items shown in the General Exclusions and Limitations section of your SPD Booklet, the following types of medical services and care are not Covered by your MCTWF Actives Plan or MCTWF Retirees Plan benefit package:
• massage therapy, or acupuncture;
• any vision correction services;
• dental treatment or operation;
• personal comfort items while hospitalized, including but not limited to telephones and televisions;
• the portion of a private room charge in excess of the rate for a semi-private room unless Medically Necessary and ordered by your Doctor;
• surgical procedures, treatment or hospitalization primarily for cosmetic purposes;
• services to correct complications arising out of cosmetic procedures even when Medically Necessary;
• any treatment or service not provided or ordered by a Physician;
• expenses that exceed specified benefit levels listed in your Schedule of Benefits;
• any medical, surgical or psychotherapy expenses related to sex change operations;
• charges for care, treatment, services and supplies that are considered Experimental or Investigative in nature and/or not considered reasonable and customary by any government agency or subdivision (including as provided in the CMS Medicare Coverage Issues Manual), except Medically Necessary services to correct complications arising out of such services;
• expenses that exceed the Maximum Allowable Benefit amount, Contracted Charges or MCTWF Actives Plan and MCTWF Retirees Plan limits;
• any treatment, except dietary counseling, maternity and wellness care that is not the result of an Accidental Injury or Illness;
• treatment for obesity when billed as an isolated diagnosis;
• medical or surgical therapies and procedures for infertility administered strictly for the purpose of conception;
• treatment for sexual impotency when the cause is mental or emotional;
• treatment of developmental disorders without a medical diagnosis as the cause of mental and/or physical development;
• bundled services provided through structured pain control/rehabilitation programs;
• benefits for Beneficiaries in a Health Maintenance Organization (HMO) that were denied because the HMO guidelines were not followed;
• expenses for transportation or lodging, other than those Covered under the Specified Organ Transplant Program or Medically Necessary use of an ambulance;
• expenses for Custodial Care, whether on an inpatient, outpatient or home care basis;
• expenses for drugs or medical supplies that are available over-the-counter;
• expenses for prescription drugs (excluding injectables administered in the Physician’s office or prescription drugs related to an approved transplant). However, these may be Covered under your prescription drug benefit;
• weight loss programs, except dietary counseling;
• charges for any service that requires prior authorization that was not prior authorized;
• charges for care, treatment, services and supplies that are not uniformly and professionally endorsed as standard medical care by the general medical community in the state where the treatment is rendered;
• developmental speech, developmental occupational, and developmental physical therapy (note: effective January 1, 2016, developmental speech therapy is no longer excluded);
• charges for non-surgical spinal decompression therapy with services dates January 1, 2016 and after;
• charges for completion of claim forms or missed appointments;
• Deductible, Copayment and Coinsurance amounts applied for treatment, procedures, or services that were previously processed by the Fund;
• expenses sustained while participating in an illegal act which is in violation of a State or Federal Statute;
• charges for services after coverage has been terminated, except if You are an MCTWF Actives Plan participant or Beneficiary Covered under the Extended Disability benefit;
• services rendered by a social worker or counselor who is not licensed in the state where services are performed;
• marriage or family counseling;
• expenses related to a transplant of an animal organ or a mechanical device to replace a human organ;
• charges You are not legally required to pay;
• charges for dyschromia (tattoo removal);
• charges for stand-by surgeons;
• charges for non-Physician surgical assistants;
• charges for educational programs or materials;
• separate charges for sales tax, surcharges and/or shipping charges;
• immunizations required for foreign travel;
• hair prosthesis, hair transplants or implants and wigs;
• expenses for employment ordered medical services;
• expenses for military service related conditions or injuries; or
• preventable Hospital acquired conditions and serious adverse events.
The MCTWF Actives Plan pays the Participant weekly benefits if he is disabled while Covered by the Fund as an Active Participant. Benefits are payable only if the Participant has ceased work as a result of his Disability. Disability means the Participant’s inability to perform the regular duties of his employment because of a non-occupational or non-auto-related Accident or Sickness or due to pregnancy. The Participant may not engage in any gainful occupation during any period of Disability. Disability benefits are not payable if they occur during a period of time the Participant would not otherwise be working if the Disability had not occurred; for example, if a Disability occurs while he is laid off, due to a personal leave or temporary work stoppage (e.g., strikes and lockouts).

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

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

Once the Participant establishes eligibility, weekly accident and sickness benefits may begin on -

- the first day following Medical Attention after the last day worked in the event of an Accidental Injury, providing that the participant is eligible for benefits on the date that the Medical Attention was received. Thus a) if medical attention is received on the last day worked, benefits would commence effective the following day or b) if medical attention is first received on a subsequent day, benefits would commence effective the day the medical attention is received; or

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

The Participant will receive an established amount each week up to an established maximum number of weeks for each period of Disability provided he is -

- unable to perform his duties of the job; and

- under the regular care of a licensed Physician who confirms the Participant’s Disability by submitting a monthly Participant Report of Disability form completed by the Physician, the Participant and his Employer. Physicians who are authorized to make such determination under the MCTWF Actives Plan must be either a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M), or an Oral Surgeon.

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

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

- the Participant returns to regular employment for at least 14 Days between disabilities; or

- the disabilities are due to unrelated causes and begin after his return to regular employment for at least one day.
SEC. 4.2: CONTINUATION OF BENEFIT ELIGIBILITY

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

4.2 (a) CONTINUATION OF BENEFIT ELIGIBILITY FOR PLANS WITHOUT WEEKLY ACCIDENT AND SICKNESS BENEFITS

For non-occupational and non-auto related disabilities that commenced (in accordance with the Fund’s rules) on or after April 1, 2013 and through April 2, 2016, full plan coverage will continue for the period of the disability, not to exceed 26 weeks, regardless of whether your benefit package provides for weekly accident and sickness benefits. Thereafter, such ongoing full benefit package coverage beyond the period of additional employer contribution, up to a maximum duration of 26 weeks of disability, will be limited to participants whose benefit package includes weekly accident and sickness benefits.

SEC. 4.3: HOW BENEFITS ARE TAXED

The Participant’s weekly accident and sickness benefits are subject to withholding for federal FICA (Social Security) tax purposes.
The MCTWF Actives Plan pays for Total and Permanent Disability (TPD) benefits if the Participant becomes Totally and Permanently Disabled due to a non-occupational or non-auto related Accidental Injury or Illness while he is Covered by the Fund as an Active Participant. Upon approval of your application for TPD benefits, all rights to the MCTWF Retirees Plan are forfeited.

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

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

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

SEC. 5.1: BENEFIT AMOUNT AND DURATION

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

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

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

The Fund has the right to recover any TPD benefits a Participant receives after he is no longer eligible for this benefit. The Fund may recover these overpayments by reducing future benefits the Participant is entitled to receive under his MCTWF Actives Plan.
The Fund provides You with prescription drug coverage for prescription fills by a retail pharmacy of up to a 34 day supply or for a 35-90 day supply, for prescription fills by a mail service pharmacy of up to a 90 day supply, and for prescription fills by a specialty pharmacy of up to a 90 day supply.

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

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

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

If a Generic Drug version of your prescribed Brand Name Drug is available, the MCTWF Actives Plan and MCTWF Retirees prescription drug benefit plan only will cover the Generic Drug version, regardless of whether your physician instructs the pharmacy to “Dispense [the Brand Name Drug] as Written” (“DAW”). If You insist on receiving the prescribed Brand Name Drug, You will be responsible for payment of the difference in the applicable charges (the “Allowed Amounts”) between the Generic Drug and Brand Name Drug and for payment of the Generic Drug Copayment or Coinsurance amount.

The only exception to this rule is if, through a prior authorization request, your physician presents to CVS/caremark, or, where applicable, to the Fund, adequate evidence of medical necessity for use of the Brand Name Drug. In such case, You will be responsible only for the payment of the Brand Name Drug Copayment or Coinsurance amount.

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

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

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

**Glucose Monitoring Supplies**

You may obtain prescribed lancets, test strips and glucose meters from any participating Network pharmacy at your MCTWF Actives Plan or MCTWF Retirees Plan’s benefit package Brand Name Drug Copayment or Coinsurance level. Accu-Chek and OneTouch test strips and lancets are the preferred brand products and do not require prior authorization. Freestyle test strips do require prior authorization.
SEC. 6.2: MAIL SERVICE PHARMACY

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

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

Ask your Physician to write two prescriptions. One prescription should be for up to a 34 Day supply, to fill at a participating retail Network pharmacy to ensure an immediate supply. The other prescription should be for up to a 90 Day supply, plus any appropriate refills. Complete a CVS/caremark Mail Service Order Form (available in your CVS/caremark Prescription Benefit booklet, from the Forms page of the Fund’s website or from our Member Services Call Center, and send it to CVS/caremark, along with your original prescription(s) (not a photocopy), and the appropriate co-payment for each prescription. You must mail in a Mail Service Order Form each time You request a new prescription through the mail service pharmacy. The mail service pharmacy will process your order and send your medication to You within 14 Days along with reorder instructions for future prescriptions or refills. In addition to ordering your prescription refills by mail, You may also order online at www.caremark.com or by contacting CVS/caremark.

If You have any questions about your medications, You can contact CVS/caremark.

Glucose Meters

You may be qualified to receive a free OneTouch or Accu-Chek glucose meter through the CVS/caremark mail service program. To qualify, your prescription must state that You are diabetic and it must provide for a 90-day supply of OneTouch or Accu-Chek test strips (or You must inform CVS/caremark mail service pharmacy that You wish to switch to One Touch or Accu-Chek) and You must not have received a free meter through the program within the last 365 days.

SEC. 6.3: SPECIALTY PHARMACY SERVICES

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

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

- Acromegaly
- Alcohol Dependency
- Allergic Asthma
- Alpha-1 Antitrypsin Deficiency
- Anemia
- Immune Deficiencies and Related Disorders
- Immune (Idiopathic) Thrombocytopenic Purpura
- Infectious Disease
- Inflammatory Bowel Disease
• Botulinum Toxins
• Cryopyrin-Associated Periodic Syndromes
• Cystic Fibrosis
• Dupuytren's Contracture
• Gastrointestinal - Other
• Gout
• Growth Hormone and Related Disorders
• Hematopoietics
• Hemophilia, Von Willebrand Disease and Related Bleeding Disorders
• Hepatitis C
• Hereditary Angioedema
• HIV Medications
• Hormonal Therapies
• Pulmonary Arterial Hypertension
• Renal Disease
• Respiratory Syncytial Virus
• Iron Overload
• Lysosomal Storage Disorders
• Macular Degeneration
• Movement Disorders
• Multiple Sclerosis
• Neutropenia
• Oncology-Injectable
• Oncology – Oral/Topical
• Osteoarthritis
• Osteoporosis
• Paroxysmal Nocturnal Hemoglobinuria
• Phenylketonuria
• Pre-Term Birth
• Psoriasis
• Rheumatoid Arthritis
• Seizure Disorders
• Systemic Lupus Erythematosus

6.3(a) SPECIALTY PREFERRED DRUG PROGRAM

If You are newly prescribed a “Non-Preferred” specialty medication for certain diseases in the following therapeutic classes the program requires that You be treated with the most common clinically effective medication:

• Autoimmune
• Chronic Myeloid Leukemia (CML)
• Hematology
• Hepatitis C
• Growth Hormone
• Multiple Sclerosis
• Osteoarthritis
• Osteoporosis
• Prostate Cancer
• Pulmonary Arterial Hypertension
• Transplant

If You are not effectively treated with that medication, You will be provided authorization for use of a “Non-Preferred” medication. This process is referred to as “step therapy.” If You were being continuously treated for any of these diseases prior to January 1, 2013 You will not be subject to this program.

6.3(b) SPECIALTY MEDICAL CARVE-OUT PROGRAM

Effective with service dates of January 1, 2016 and after, CVS/caremark's Specialty Medical Carve-Out Program (Program) will apply. Under the Program, oral and injectable specialty medications, other than those for cancer treatment, which are provided and/or administered by a physician will be “carved-out” of the Fund’s medical benefit and covered under the Fund’s pharmacy benefit. The specialty medication will be available to the provider or patient through the CVS/caremark specialty pharmacy. The Program will manage utilization through prior authorization, step therapy, dose/waste claim management, and education.
SEC. 6.4: PRESCRIPTION DRUG PRIOR AUTHORIZATIONS

Certain prescription drug classifications, or Brand Name Drugs (brands) and Generic Drugs ( generics) within those classifications, require prior authorization. Have your Physician contact CVS/caremark to obtain authorization for the following medications:

- anabolic steroid drugs;
- androgens brands Androgel, Fortesta, Natesto, Testim or Vogelxo and generic testosterone gel 1%;
- angiotensin II receptor antagonists brands Atacand, Diovan, Edarbi or Teveten;
- angiotensin II receptor antagonists/diuretic combinations brands, Atacand HCT, Diovan, Edarbi or Teveten HCT;
- angiotensin II receptor antagonists/calcium channel blocker/diuretic combinations brand Exforge HCT;
- aminosalicylates brands Asacol HD or Delzicol;
- anaphylaxix treatment brand Adrenaclick;
- anticholinergics brands Incruse Ellipta or Tudorza;
- antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs) brand Cymbalta;
- antidepressants, miscellaneous agents brand Qleptro;
- anti-obesity drugs;
- attention deficit hyperactivity disorder/narcolepsy drugs (age 20 and above) Adderall XR or Intuniv;
- antipsychotics, atypicals brand Abilify;
- actinic keratosis brand Carac or generic fluorouracil cream 0.5%;
- benign prostatic hyperplasia agents/combination brand Jalyn;
- beta agonist, short-acting brands Proventil HFA, Ventolin HFA or Xopenex HFA;
- biguanides brands, Glumetza or Riomet;
- calcium channel blocker brands Norvasc, Cardizem Cardize CD, Cardizem LA, and generics cardizem LA or matzim;
- corticosteroids brand Rayos;
- cytomegalovirus agents brand Valcyte;
- dermatology skin inflammation and hives corticosteroids brands Apexicon E, Oulx-E or Clobex Spray and generic clobetasol spray;
- diabetes biguanides brands Fortamet, Glumetza or Riomet;
- diabetes supplies Accu-Chek strips and kits, Breeze 2 strips and kits, Contour strips and kits, Contour Next strips and kits, Freestyle test strips and all other test strips that are not Onetouch brand;
- dipeptidyl peptidase-4 (DPP-4) inhibitors brands Nesina or Onglyza;
- dipeptidyl peptidase-4 (DPP-4) inhibitor combinations brands Kazano, Kombiglyze XR or Oseni;
- fibrates brand Tricor;
- growth hormone brands Genotropin, Nutropin AQ, Omnitrope, Saizen or Tev-Tropin;
- hepatitis C agents brand Viekira Pak;
- herpes agents brand Valtrex;
- HMG/Co-A reductase inhibitors (HMG or Statins)/Combinations brands Advicor, Altoprev, Lescol XL, Lipitor Liptruzet or Livalo;
- hypnotic, non-benzodiazepines brands Intermezzo, Lunesta or Rozerem;
- insulin brands Apida, Humalog, Humalog mix 50/50, Humalog mix 75/25, Humulin 70/30, Humulin N or Humulin R;
- insulin sensitizers brand Noritate;
Injectable incretin mimetics brands Bydureon or Byetta;
Immunosuppressants, calcineurin inhibitors brand Hecoria;
Irritable bowel disease - constipation predominant brand Amitiza;
Multiple sclerosis agents brands Avonex, Extavia or Plegridy;
Musculoskeletal agents Amrix;
Nasal steroid/combinations brands Beconase Aq, Dymista, Omnaris, Qnasl, Rhinocort Aqua Veramyst or Zetonna;
Newer anti-obesity agents Qsymia;
Nonsteroidal anti-inflammatory drugs (NSAIDs)/combination brands Arthrotec, Duexis, Flector Naprelan, Pennsaid, and Vimovo;
Ophthalmic brand Lastacaft;
Opioid dependence agents brand Zubsolv;
Oral acne drugs;
Oral anti-fungal drugs;
Phosphate binders brand Forsrenol;
Phosphodiesterase inhibitors brand Levitra or Viagra (limited to six every 34 days at retail and 20 every 90 days at retail (90) and mail service. See Sec. 6.8, Prescription Drug Limitations) Cialis prescribed for once daily use of 2.5 mg or 5 mg dose, for the treatment of benign prostatic hypertrophy;
Prostaglandin analogs brand Lumigan;
Rosacea brand Noritate;
Sodium-glucose co-transporter-2 (SGLT2) inhibitors brand Invokana;
Sodium-glucose co-transporter-2 (SGLT2) inhibitor/biguanide combinations brand Invokamet;
Steroid inhalants brands Aerospan and Alvesco;
Steroid/beta agonist combination brand Symbicort;
Topical acne drugs (age 26 and above);
Urinary antispasmodics brands Detrol LA, Oxytrol, or Toviaz;
Vicosupplements brands Euflexxa, Monovisc and Orthovisc;

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

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

To obtain prior authorization, your physician must contact CVS/caremark (See Important Phone Numbers).

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

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

Authorization is contingent upon -

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

Effective with prescriptions filled on or after January 1, 2016, Fund coverage will cease except, if You have an existing Fund authorization as of December 31, 2015, You will remain covered for the remainder of the authorization period, subject, of course, to otherwise maintaining eligibility for Fund prescription drug benefits.

6.5(b) PROTON PUMP INHIBITORS - CRITERIA FOR AUTHORIZATION

Authorization is contingent upon -
• a documented failure of treatment (minimum of 2 week trial) with OTC proton pump inhibitors;
• an adverse reaction or intolerance to OTC proton pump inhibitors; or
• an adverse drug interaction or potential adverse interaction with OTC proton pump inhibitors.

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

Effective with prescriptions filled on or after January 1, 2016, You are allowed 90 units of generic proton pump inhibitors per 365 day period without needing prior authorization. If You request brand proton pump inhibitors, or treatment for longer than 90 days per 365 day period, prior authorization is required and administered by CVS/caremark to determine whether medical necessity requirements are satisfied. If You have an existing Fund authorization as of December 31, 2015, You will remain covered for the remainder of the authorization period, subject, of course, to otherwise maintaining eligibility for Fund prescription drug benefits.

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

SSRIs are a therapeutic class of prescription drugs that are commonly referred to as psychostimulants or antidepressants. The Fund's SSRI step therapy program requires that if your Physician wishes to place You on a Brand Name SSRI You must first try one Generic SSRI for a minimum period of 60 Days within a 12 month period. If your Physician still wishes to place You on a Brand Name SSRI, You must receive prior authorization by contacting CVS/caremark. If You satisfy the requirement and commence use of a Brand Name SSRI, You will remain eligible without limitation for the duration of treatment. If You wish to resume SSRI treatment after a lapse of one year, You will be subject to the one Generic SSRI trial and prior authorization requirement before obtaining approval for coverage of a Brand Name SSRI.
**SEC. 6.7: COMPOUND DRUGS**

In general, compounding is defined as a practice in which a licensed pharmacist combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. Some compounds are medically indicated, such as liquid doses compounded from solids to permit pediatric use and those that are free of dyes or other ingredients that cause allergic reactions, whereas many of the higher priced compounds contain excessively priced bulk powders and proprietary compounding bases that, in addition, may be lacking documented evidence of clinical efficacy. Therefore, all compound drug claims exceeding $300 are subject to review for medical appropriateness by CVS/caremark (i.e., through consideration of physician prior authorization requests) and all compound drug fills, regardless of the charge, will be limited to one fill of the same compound per 34 days. To obtain prior authorization for compound medications that exceed $300, your physician must contact CVS/caremark (see Important Phone Numbers). Effective with prescriptions filled on or after January 1, 2016, coverage will be denied for proprietary compounding bases, bulk compounding powders, and compounding kits and for select topical compounded analgesics (pain patches).

**SEC. 6.8: PRESCRIPTION DRUG LIMITATIONS**

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

- **erectile dysfunction tablets** - such as Caverject®, Edex®, Muse®, Levitra® (with regard to Levitra®, see Sec. 6.4, Prescription Drug Prior Authorizations “phosphodiesterase inhibitor”) and Cialis® (except for Cialis® when prescribed for once daily use of 2.3 mg or 5 mg dose for the treatment of benign prostatic hypertrophy, see Sec. 6.4, Prescription Drug Prior Authorizations) at a quantity limit of six every 34 days at retail and 20 every 90 days at retail (90) and mail service, regardless of strength;

- **influenza treatment and preventions** - such as Relenza® tablets, Tamiflu® 75 mg tablets and Tamiflu® suspension at a treatment quantity of one every six months at retail, retail (90) and mail service;

- **smoking cessation** - For those covered under the MCTWF Retirees Plan, a maximum continuous drug therapy for any prescription drug is limited to coverage for 180 Days per a 12 month period and a lifetime maximum of two Years of therapy; and MCTWF Actives Plan health benefit packages are non-grandfathered and in compliance. For those covered under the MCTWF Actives Plan, the number of covered, appropriate, in-network counseling sessions for those diagnosed with tobacco use disorder is unlimited. Coverage for FDA approved, physician prescribed tobacco cessation medications purchased from an in-network pharmacy fall into two categories, Nicotine Replacement Products (patch, gum, lozenges, Nicotrol inhalation system, and Nicotrol NS nasal spray) and Nicotine Deterrent Products (Chantix or Bupropion). No cost coverage for any physician prescribed product or combination of products in each category is limited to 168 days per calendar year.

- **other limitations** - Prostin VR® is Covered through age two, Elidel® is Covered for ages three and over and Protopic® is Covered for ages three and over.
SEC. 6.9: PRESCRIPTION DRUG REIMBURSEMENT

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

• when eligibility is established retroactively after a prescription is filled through no fault of yours, You will be reimbursed 100% of charges, less the applicable Copayment;
• when a prescription is filled prior to establishing COBRA continuation coverage, You will be reimbursed the CVS/caremark Allowed Amount determined to be appropriate, less the applicable Copayment;
• when You fill a prescription that is rejected, but is subsequently approved pursuant to the Fund’s Medical Director review, You will be reimbursed the CVS/caremark Allowed Amount determined to be appropriate, less the applicable Copayment;
• when You fill a compound prescription that is rejected and subsequently approved pursuant to CVS/caremark’s review, You will be reimbursed the CVS/caremark Allowed Amount determined to be appropriate, less the applicable Copayment; and
• when You fill a prescription at a non-participating (Out-of-Network) pharmacy, You will be reimbursed the amount determined by CVS/caremark to be appropriate, less the applicable Copayment.

When submitting a request for reimbursement of a prescription, You must fill out a CVS/caremark Prescription Drug Claim Form available on the Fund’s website or in your CVS/caremark Prescription Benefit booklet, along with an itemized receipt.

SEC. 6.10: PRESCRIPTION DRUG EXPENSES NOT COVERED

Your prescription drug benefit does not cover the following items:

• charges for any take-home drugs (for example, drugs brought home after out-patient surgery);
• any charges for therapeutic devices or appliances, regardless of their intended use;
• drugs or medicines supplied to the individual by a prescribing Physician or dentist;
• cosmetic or beauty aids, and diet supplements;
• immunizing agents, injectables, blood or blood plasma or medication prescribed for parenteral administration, except insulin and insulin syringes;
• existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are Experimental in nature or any drug labeled “Caution: Limited by Federal Law to Investigational Use”;
• any charge for administration of Covered drugs;
• any charge for prescription refills in excess of the number of refills specified by your Physician or dentist, or any refill dispensed after one year from the date of the original prescription;
• the charge for any medication You are entitled to receive without charge from any municipal, state or federal program, whether contributory or not, except for Medicaid;
• medications that are not FDA-approved and that have not been proven effective for the conditions for which they are being used;
• charges for a Brand Name Selective Serotonin Reuptake Inhibitor (SSRI) prescription drugs without first satisfying the SSRI step therapy requirement;
• charges for non-sedating antihistamine prescription drugs;
• charges for brand proton pump inhibitor (PPI) prescription drugs and for generic PPI prescription drug treatment for longer than 90 days per 365 day period without first receiving prior authorization;
• charges for medications listed in Sec. 6.4, Prescription Drug Prior Authorizations, without first receiving prior authorization;
• charges for medications that exceed the limitations listed in Sec. 6.8, Prescription Drug Limitations;
• drugs that cost less than your Copayment;
• refills not authorized by a Physician; and
• any expenses shown in General Exclusions and Limitations listed in Part 1.

SEC. 6.11: NOTICE OF CREDITABLE COVERAGE - ALL FUND BENEFIT PACKAGES WITH PRESCRIPTION DRUG COVERAGE

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


Please read this notice carefully and keep it where You can find it. This notice has information about your current prescription drug coverage with the Fund and about your options under Medicare’s prescription drug coverage. This information can help You decide whether or not You want to join a Medicare Prescription Drug Plan. If You are considering joining, You should compare your current coverage, including which drugs are Covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where You can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Fund has determined that the prescription drug coverage offered by all Fund benefit packages with prescription drug coverage, on average for all Plan Participants, are expected to pay out as much as standard Medicare prescription drug coverage pays and therefore are considered Creditable Coverage. Because your existing coverage is Creditable Coverage, You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare Drug Plan.

You can join a Medicare Drug Plan when You first become eligible for Medicare and each year from October 15th through December 7th. However, if You lose your current creditable prescription drug coverage, through no fault of your own, You will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug Plan.
If You decide to join a Medicare Drug Plan, under the Fund rules You nonetheless may not drop your Fund prescription drug coverage. If You have both Fund prescription drug coverage and Medicare prescription drug coverage, the Fund prescription drug coverage will be primary and your Medicare Prescription Drug Plan will be secondary. If You are a COBRA Beneficiary You may drop your Fund coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug Plan. However, You will not be eligible to get Your Fund COBRA coverage back later. If You do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug Plan coverage. You should compare your current coverage, including which drugs are Covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug Plan provides comprehensive coverage for eligible prescription drugs, subject to prior authorization requirements for certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs (effective January 1, 2016), non-sedating antihistamines (until December 31, 2015, thereafter not covered), proton pump inhibitors (after a 90 day generic supply during 365 day period or if brand is requested, effective January 1, 2016), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs with both retail and mail order availability, subject to Generic and Brand copayments, as detailed in your Summary Plan Description Booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and You still will be eligible to receive all of your current health and prescription drug benefits if You choose to enroll in a Medicare Prescription Drug Plan.

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

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

Contact the Fund’s Member Services call center at (313) 964-2400 or (800) 572-7687. NOTE: You’ll get this notice each year. You will also get it before the next period You can join a Medicare Drug Plan, and if this coverage through the Fund changes. You also may request a copy of this notice at any time.

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

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

• visit www.medicare.gov;
• call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help; or
• call 1-800-MEDICARE (1-800-633-4227). TTY users should call 877-486-2048.
If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at www.socialsecurity.gov, or you can call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are not required to pay a higher premium (a penalty).
PART 7: DENTAL BENEFITS - MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

SEC. 7.1: CHOICE OF DENTAL PROVIDERS

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

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

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

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

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

SEC. 7.2: PREDETERMINATION OF BENEFITS

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

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

7.2(a) OBTAINING A PREDETERMINATION OF BENEFITS

To obtain a predetermination of benefits, have your dentist fill out a claim form or electronically submit a claim form directly to Delta Dental of Michigan showing the proposed treatment and costs. You may obtain a claim form from the Fund by calling the Member Services Call Center or from the Forms page of the Fund’s website.

Both you and your dentist will receive a statement of predetermination showing the amount that your MCTWF Actives Plan or MCTWF Retirees Plan benefit package pays for the dental procedure. Generally, this amount will only be paid if you receive the treatment within 90 Days of the date of the predetermination.
SEC. 7.3: ALTERNATE PROCEDURES

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

SEC. 7.4: COVERED DENTAL EXPENSES

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

Class I - diagnostic and preventive services.
Class II - basic restorative services.
Class III - major restorative services.
Class IV - orthodontic services.

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

Class I Covered dental services and supplies include -

• oral examination, prophylaxis (cleanings) twice per calendar year;
• full mouth x-rays every five years per dental specialty;
• bitewing x-rays twice per calendar year;
• laboratory and diagnostic tests;
• fluoride treatments twice per calendar year for Dependents up to age 14;
• brush biopsy test;
• emergency palliative treatment;
• space maintainers;
• sealants for first and second permanent molars of Dependent children up to age 15 with high risk teeth. A 25% Coinsurance charge applies. This service must be prior authorized by the provider by submitting a written request to the Fund's Utilization Review Department; and
• repair or reapplication of Dependent child sealants beyond three years from the sealant application date. A 25% Coinsurance charge applies. This service must be prior authorized by the provider by submitting a written request to the Fund's Utilization Review Department.

Class II Covered dental services and supplies include -

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

Class III Covered dental services and supplies include -

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

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

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

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

The MCTWF Actives Plan and MCTWF Retirees Plan pays for the following expanded dental preventative services for Covered individuals with certain high risk medical conditions:

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

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

7.4(b) COVERED DENTAL EXPENSES AFTER ELIGIBILITY CEASES

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

• the completion of dentures (full or partial) if the impression was made prior to the loss of eligibility;
• the completion of fixed bridgework, restorations and crowns if the tooth or teeth were prepared prior to the loss of eligibility; and
• the completion of root canal therapy if the tooth or teeth were opened for treatment prior to
the loss of eligibility.
Dental claims for these services initially will be denied. To have the claim reconsidered, the dentist then must resubmit the claim with a copy of your chart to document that the date the treatment commenced was prior to the loss of your eligibility.

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

SEC. 7.5: IF YOU DO NOT HAVE ACCESS TO NETWORK GENERAL DENTISTS OR ORTHODONTIC PROVIDERS
In the event You live further than 20 driving miles (as determined by the Fund) from a Network general dentist, You will have the option of seeking care from a dentist of your choice. Please note that dental specialists, are not Covered. To obtain such exemption, You must apply utilizing Non-Access Exemption Application. Authorization to use an Out-of-Network provider will be determined on a per application basis and will continue for six months from the date that the first Out-of-Network services are rendered.

Similarly, in the event You live further than 25 driving miles (as determined by the Fund) from a Network orthodontist, You will have the option of seeking care from an orthodontist of your choice. To do so, You must apply for an exemption to use an Out-of-Network provider. To obtain such exemption, You must apply utilizing a Non-Access Exemption Application. Authorization to use an Out-of-Network provider will be determined on a per application basis and will continue for the length of the treatment.

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

7.5(a) NON-ACCESS EXEMPTION APPLICATION
To be accepted, your application must be received by the Fund within 60 Days following the receipt of Out-of-Network services. If your application is approved, the claim will be deemed as Out-of-Network and all applicable Coinsurance and benefit maximum amounts will apply. Once your application to use an Out-of-Network general dentist is approved, the approval will continue for six months from the date that the first Out-of-Network services are rendered. In the case of orthodontic services, that approval will continue through the length of treatment. Any services beyond the treatment period must be authorized pursuant to the submission and approval of a new application. You may obtain a Non-Access Exemption Application form, by calling the Fund’s Member Services Call Center or from the Fund’s website.
SEC. 7.6: DENTAL EXPENSES NOT COVERED

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

• appliances, restorations or services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ). This may be Covered under the MCTWF Actives Plan and MCTWF Retirees Plan medical benefits;
• treatment given by anyone who is not a licensed dentist or dental practitioner, except charges for dental prophylaxis performed by a dental hygienist under the supervision and direction of a dentist;
• temporary restoration;
• charges for sealants, except for first and second permanent molars of Dependent children up to age 15 with high risk teeth and with prior authorization. High risk means teeth which have caries (tooth decay) in one or more molars;
• repair or reapplication of sealants for Dependent children within three Years from the sealant application date;
• charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
• procedures, services or supplies that are Experimental in nature;
• procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, or for increasing vertical dimension, splinting or replacing tooth structure lost as the result of abrasion or attrition;
• drugs, medicaments, prescriptions, other than the injection of antibiotics;
• inlays;
• charges made by a Hospital;
• expenses for root canal treatment and/or apicoectomies when previously paid;
• expenses for services or appliances started before the effective date of coverage under your MCTWF Actives Plan and MCTWF Retirees Plan;
• expenses for replacement made less than five Years after placement or replacement that was Covered by the MCTWF Actives Plan or MCTWF Retirees Plan including crowns, onlays, substructures (including pins, posts, cores and thimbles), fixed bridges, implants, removable prosthetic appliances and occlusal adjustment;
• limited occlusal adjustment not more than three times in a five year period;
• general anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary;
• benefits or services that are available from any government agency, political subdivision, community agency, foundation, mutual benefit association, labor Union trust or similar group or any similar entity;
• expenses for extension of bridges or prosthetic devices previously paid for by the MCTWF Actives Plan or MCTWF Retirees Plan incurred in new extended areas;
• orthodontic expenses for those over age 19, if provided by an Out-of-Network provider;
• orthodontic expenses for Participants and Spouses under age 19, if provided by an Out-of-Network provider;
• services or supplies received as a result of dental disease or injury due to an act of war, declared or undeclared;
• expenses for mouth guards and associated devices;
• services as determined by the Fund for cosmetic surgery or dentistry for aesthetic reasons;
• any expenses incurred that exceed the dental/orthodontia services Annual and/or lifetime maximums;
• porcelain, porcelain substrate, and cast restorations for Dependent children less than 12 years of age;
• fixed bridges and removable cast partials for Dependent children less than 16 years of age;
• oral examination, prophylaxis (cleaning) more than two times per calendar year, except for high risk medical conditions (see Sec. 7.4, Covered Dental Expenses for High Risk Medical Conditions);
• bitewing x-rays more than two times per calendar year;
• full mouth or panoramic x-rays more than once in a five year period per dental specialty, except when there is adequate evidence that an additional x-ray is clinically necessary;
• fluoride treatments for Dependents up to age 14 more than two times per calendar year;
• fluoride treatment for Dependents age 14 and over;
• reline or complete replacement of denture base material more than once in any three-year period per appliance;
• cosmetic services including teeth whitening; or
• all porcelain composition crowns seated in the posterior portion of the mouth;
• dental services or supplies as determined by Delta Dental, for which no valid dental need can be demonstrated, or that are investigational in nature (including service or supplies required to treat complications from investigational procedure), or that are a specialized technique, or that are not provided in accordance with generally accepted standards of dental practice;
• dental services for dependent children if covered under the MCTWF Retirees Plan.
SEC. 8.1: CHOICE OF VISION PROVIDERS

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

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

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

The Fund is required to furnish You upon request and without charge a list of its Network of vision providers. This list is referred to as the participating provider directory. You may also visit the Fund’s website to link to the Davis Vision website to obtain an up-to-date list of Network vision providers.

SEC. 8.2: IN-NETWORK OPTION

The in-network option provides You coverage as follows:

- coverage in full for eye examinations and clear plastic single, bifocal, trifocal and lenticular lenses;

- Davis Vision Fashion, Designer and Premier collection frames are covered up to a lower fixed dollar amount for frames than non-Davis Vision Collection Frames, which are covered up to a fixed dollar amount; You are responsible for any amount over the allowance after a discount of 20% of the excess is applied. Discounts do not apply to products purchased from Costco, Wal-Mart, or Sam’s Club;

- Davis Vision Collection frames and lenses and all frames and lenses purchased from a network provider that does not carry Davis Vision Collection frames come with a free one-year breakage warranty.

- coverage up to a fixed dollar amount for progressive lenses; You are responsible for the balance up to specific maximum charges for standard, premium or ultra clear plastic lenses. For lenses other than clear plastic, there may be an additional charge, both in-network and out-of-network;

- coverage is not provided for lens treatments, however, You are only responsible for charges up to specific maximums for the following single, bifocal, trifocal, lenticular or progressive lens treatments: tinting (plastic only), scratch-resistant, scratch protection plan: single vision/multifocal, polycarbonate lenses age 19 or greater (under age 19 covered in full), UV protection (plastic only), anti-reflective: standard/premium/ultra photochromic lenses (plastic only), polarized (plastic only), oversize and high-index;

- coverage up to a fixed dollar amount for contact lenses. You are responsible for any amount over the allowance after a discount of 15% of the excess is applied. Discounts do not apply to products purchased from Costco, Wal-Mart, or Sam’s Club. You are responsible for the first $60 of the contact lens fitting; and

- coverage up to a fixed dollar amount per eye per lifetime for laser vision correction any amount over the allowance, additional discounts of up to 25% off the provider’s usual & customary fees, or 5% off advertised specials (whichever is lower) is available.

- If You utilize an ophthalmologist (medical doctor specializing in diseases of the eye) and do not have a medical eye condition, services will be covered under the vision portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the Davis Vision network.
The MCTWF Actives Plan or MCTWF Retirees Plan pays for one exam and one vision correction option per person per calendar year. Benefits based on a per lifetime limit for laser vision correction and a calendar year limit for all other vision options. A vision option is defined either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. **Note:** Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.

When using a Network provider, your MCTWF Networks Card should be presented.

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

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

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

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

- services or supplies to correct a vision defect that happens as the result of a work-related or auto-related Accidental Injury or Illness;
- services or supplies received from a vision department maintained by a mutual benefits association, labor Union or other similar group;
- vision services or supplies received more frequently than allowed;
- treatment given by someone who is not a licensed optometrist, ophthalmologist or optician;
- any service or procedure not specifically included or exceed limits stated in the Schedule of Benefits;
- the charges for polycarbonate lenses in excess of the Allowed Amount for basic lenses, for anyone age 19 and over;
- vision services for dependent children if covered under the MCTWF Retirees Plan;
- sunglasses, plain or prescription, or safety lenses or goggles, tinting or photochromic lenses;
- any out-of-network lens treatments including scratch resistant, ultra violet, tinted or anti-reflective;
- procedures, services or supplies that are Experimental in nature;
- orthoptics, vision training or aniseikonia; or
- repairs of any kind.

Services within an optometrist’s licensed scope of treatment that meet MCTWF’s medical necessity criteria, whether using a Network or Out-of-Network provider, may be reimbursed as a medical benefit; the diagnoses and services billed will determine whether eligible claims will be reimbursed as a medical or vision benefit.
**SEC. 9.1: EMPLOYEE DEATH BENEFIT**

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

- your beneficiary is not entitled if You die while You are receiving total and permanent disability benefits, COBRA continuation coverage, extended disability benefits, or when incurred during benefit bank weeks;
- death benefits for death by suicide will not be paid unless You have been actively and consecutively Covered under the MCTWF Actives Plan for a period of 24 or more months. If You finish work for one work week and die during the following work week in the gap period prior to your scheduled return to work, your death benefit is payable; and
- for death due to Illness of first year Participants, the benefit amount is limited to that contained in the MCTWF Actives Plan benefit package from which the medical benefit derives. This limitation affects only those Covered under an MCTWF Actives Plan with increased death benefits, and does not apply if the death is Accidental. Beneficiary designations must be in writing and filed with the Fund. You may name anyone You wish as your beneficiary by completing your Fund Enrollment Card. If You designate a beneficiary who is a minor, the Fund can only pay the death benefit to a guardian or conservator with full authority to access, receive and dispose of the named minor’s assets, as so appointed by Order of the Probate Court. You can change your beneficiary at any time by completing and signing Change of Beneficiary Form provided by the Fund by contacting the Fund’s Member Services Call Center or on the Forms page of the Fund’s website.

**SEC. 9.2: BENEFICIARY DEATH BENEFIT**

The Fund provides death benefits for your Spouse and your Dependent children through the end of the child’s 26th birthday month. A benefit is payable to You if a Beneficiary dies from natural or Accidental causes. Death benefits for a Beneficiary’s death by suicide will not be paid unless the Participant has been actively and consecutively Covered under the MCTWF Actives Plan for a period of 24 or more months.

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

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

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

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

If You don’t name a beneficiary or if You have no surviving beneficiary, benefits will be paid to your estate. You are automatically designated as the beneficiary for your Spouse and Dependent children.
Accidental death and dismemberment (AD&D) benefits are paid if the Participant dies or is seriously injured as a result of an Accident. AD&D benefits may be paid in addition to Active death benefits, but not in addition to Retiree Death Benefit Program benefits.

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Benefit</th>
<th>Who Receives</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Participant dies</td>
<td>100% of benefit maximum</td>
<td>Participant's Beneficiary</td>
</tr>
<tr>
<td>Participant's loss of both hands or feet</td>
<td>100% of benefit maximum</td>
<td>Participant</td>
</tr>
<tr>
<td>Participant's loss of the sight of both eyes</td>
<td>100% of benefit maximum</td>
<td>Participant</td>
</tr>
<tr>
<td>Participant's loss of one hand and one foot</td>
<td>100% of benefit maximum</td>
<td>Participant</td>
</tr>
<tr>
<td>Participant's loss of one hand and the sight of one eye</td>
<td>100% of benefit maximum</td>
<td>Participant</td>
</tr>
<tr>
<td>Participant's loss of one hand or one foot</td>
<td>50% of benefit maximum</td>
<td>Participant</td>
</tr>
<tr>
<td>Participant's loss of the sight of one eye</td>
<td>50% of benefit maximum</td>
<td>Participant</td>
</tr>
</tbody>
</table>

Accidental death and dismemberment benefits are not available to the Participant’s Beneficiaries.

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

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

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

- Illness, whether physical or mental, or medical or surgical treatment;
- ptomaine, or bacterial infections, except infection caused by a visible wound resulting from an Accidental Injury or Illness;
- suicide while sane or insane, or any intentionally self-inflicted Accidental Injury or Illness;
- death as the result of the deceased Participant’s impaired conduct, of whatever nature, caused by the voluntary or involuntary use of alcohol beyond the legal limit for operation of a motor vehicle, or misuse of drugs;
- war, or any act of war, whether declared or undeclared;
- an insurrection or participation in a riot;
- commission of a crime; or
- losses occurring 90 Days beyond the date of the Accidental Injury that resulted in the loss.
The Retiree Death Benefit provides death benefits for MCTWF Retirees Plan Retirees and their Spouses. Eligible Retirees and their Spouses individually may choose the amount of death benefit each wishes to have, from $1,000 up to $10,000.

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

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

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

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

**SEC. 11.2: TERMINATION OF COVERAGE**

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

- date the Retiree dies, or, for Spouse coverage, the date the Spouse dies;
- failure to file a Contribution within the time required; or
- the date of termination of the Retiree Death Benefit Program as determined by the Trustees or an amendment to the Retiree Death Benefit Program eligibility requirements by the Trustees that make the Retiree or Spouse no longer eligible for coverage under the Retiree Death Benefit Program.
The Flexible Dependent Coverage benefit provides a health reimbursement account to cover certain medical, dental and vision expenses for You that are not reimbursed by the Fund or other group health plans and that are deductible from an individual tax return if itemized (pursuant to section 213(d) of the Internal Revenue Code).

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

SEC. 12.1: HEALTH REIMBURSEMENT ACCOUNT CREDITS

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

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

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

Eligible expenses are -
• abortion;
• acupuncture;
• alcoholism treatment;
• ambulance service;
• artificial limbs;
• artificial teeth;
• birth control pills;
• Braille books and magazines;
• breast reconstruction surgery following mastectomy;
• mastectomy bras that exceed the four allowable per calendar year;
• capital expenses for home medical equipment or improvements for medical care;
• car controls and equipment for disabled persons;
• chiropractic care;
• Christian Science Practitioner;
• contact lenses;
• Contribution copayments for an MCTWF Actives Plan that are paid on a post-tax basis;
• Copayments and Deductibles paid under the MCTWF Actives Plan;
• crutches;
• dental treatment;
• diagnostic tests;
• diagnostic imaging;
• disabled Dependent care;
• Doctor’s fees;
• duplicate prosthetic devices;
• drug addiction inpatient treatment;
• drugs requiring a prescription;
• eyeglasses;
• eye surgery;
• fertility enhancement;
• guide dogs or other service animal;
• health institute treatment prescribed by a Physician;
• hearing aids and examinations;
• hearing treatment;
• Hospital services;
• insulin;
• lab fees;
• lead based paint removal, when child has lead poisoning;
• learning disability tuition;
• legal fees necessary to authorize treatment for mental illness;
• legal fees associated with procuring an egg donor for the direct purpose of correcting infertility;
• lifetime care (i.e., advance payments ensuring lifetime care in a retirement home, medical portion);
• lodging in Hospital or similar institution while receiving care;
• long-term care premiums and unreimbursed expenses;
• meals at Hospital or similar institution while receiving inpatient care;
• medical equipment, supplies, or diagnostic devices to the extent that such items mitigate the effect of an Accidental Injury or Illness or assist in the treatment of the Accidental Injury or Illness (with or without a prescription);
• medical services;
• medicines prescribed by a Physician;
• mentally retarded, special home;
• nursing home services (Medically Necessary);
• nursing services;
• operations (i.e. medical expenses You pay for operations that are not medically unnecessary cosmetic surgeries);
• optometrist’s fees;
• organ transplants;
• osteopath;
• oxygen;
• periodontal fees;
• prostheses;
• psychiatric care;
• psychoanalysis;
• psychologist;
• psychotherapy (by approved provider);
• special schools for the handicapped;
• sterilization (i.e., legally performed surgery for the purpose of making a person unable to have children);
• smoking cessation programs (does not include non-prescription drugs such as nicotine gum and patch);
• surgery;
• telephone for the deaf;
• television equipment for hearing impaired;
• therapy received as medical treatment;
• transplant donor expenses;
• transportation for medical care;
• tuition (i.e., medical expense charges for medical care included in tuition of a college/private school);
• vasectomy;
• vitamins requiring a prescription;
• vision correction surgery (such as LASIK or radial keratotomy);
• weight-loss program - if prescribed by Physician with respect to specific disease (includes group fees; does not include dues for gym, health club, or spa; does not include diet food or beverage unless food does not satisfy normal nutritional needs, food alleviates or treats an Illness, and need for the food is substantiated by a Physician);
• wheelchair or autoette; and
• wig purchased upon the advice of a Physician.

12.1(b) EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses not eligible for your reimbursement account include but are not limited to -
• any expense You deduct on your individual tax return;
• babysitting, child care, nursing services for normal, healthy baby;
• controlled substances;
• cosmetic surgery (unless necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an Accident or trauma, or a disfiguring disease);
• dancing/swimming lessons (even if recommended for general improvement of your health);
• diaper service;
• electrolysis/hair removal;
• expenses for trip or vacation taken for a non-medical reason;
• funeral services;
• hair transplant;
• household help;
• illegal operations and treatments;
• health club dues;
• maternity clothes;
• meals and lodging away from home for medical treatment not received at a medical facility;
• medical savings account Contributions or distributions;
• nutritional supplements not requiring a prescription;
• over-the-counter medicines and medical aids (except for insulin);
• personal use items;
• psychoanalysis You receive as a part of your training to be a psychoanalyst;
• teeth whitening procedures; or
• weight-loss programs even if your Doctor recommends the program for your general health or if for improving appearance or sense of well-being, or diet foods that substitute for normal food.

SEC. 12.2: REIMBURSEMENT PROCEDURES

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

Reimbursement from your account can be made up to twice yearly depending upon whether You choose to make semi-annual or Annual submissions for reimbursement, as follows:
• in order to qualify for reimbursement of eligible expenses incurred (i.e., paid for) between January and June, You may submit them between July 1st and August 31st of that year; and/or
• for reimbursement of expenses incurred between July and December or throughout the entire calendar year, You may submit them between January 1st and March 31st of the following year or, if You are submitting them for the first time for the prior year, You may submit them between January 1st and May 31st.

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

When You request reimbursement from your account, You must submit a Flexible Dependent Coverage Benefit Claim Form along with your paid receipts, rejections or proof that the other group health plan has paid its maximum benefits. All receipts must reflect payment in full, must contain a written description of the service/expense, must be a qualified service/expense and must not be an expense reimbursable by another policy or Plan. You may call the Fund’s Member Services Call Center for additional Flexible Dependent Coverage Benefit Claim Forms, or obtain one from the Fund’s website.
Sums credited to your account may be used only for expenses that You incur during periods in which You -
• are eligible under the MCTWF Actives Plan; and
• participate in the Flexible Dependent Coverage benefit.

Sums credited to your account will be forfeited if reimbursement is not requested before April 1st of the year following the year in which You incurred the eligible expenses.
If You use Network providers, they will file claims and will be paid pursuant to contract. If your Out-of-Network provider requests a claim form, it is available by calling the Fund’s Member Services Call Center or from the Forms page of the Fund’s website. To check on the status of your claim, You may contact the Fund’s Member Services Call Center or through the Fund’s Participant Web Portal.

SEC. 13.1: CLAIMS FOR MEDICAL BENEFITS

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

SEC. 13.2: CLAIMS FOR WEEKLY ACCIDENT AND SICKNESS BENEFITS - MCTWF ACTIVES PLAN

You must submit a Participant’s Report of Disability claim form to the Fund for weekly accident and sickness benefits which can be obtained by contacting the Fund’s Member Services Call Center or on the Forms page of the Fund’s website. You must complete the section of the form entitled “Participant Information,” your Doctor must complete the “Physician’s Statement” portion of the form and your Employer must complete the section called “Employer’s Statement.”

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

SEC. 13.3: CLAIMS FOR TOTAL AND PERMANENT DISABILITY BENEFITS - MCTWF ACTIVES PLANS

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

SEC. 13.4: CLAIMS FOR PRESCRIPTION DRUG BENEFITS

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

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>The Fund Level of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCTWF Actives Plan or MCTWF Retirees Plan eligibility applicable established</td>
<td>Reimburse 100% of charges, less the co-payment.</td>
</tr>
<tr>
<td>retroactively after prescription filled through no fault of the Participant</td>
<td>(e.g., contributions not received timely from a newly Contributing Employer).</td>
</tr>
</tbody>
</table>
INcircumstances the Fund Level of Reimbursement

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>The Fund Level of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription filled prior to establishing COBRA continuation coverage.</td>
<td>Reimburse the amount determined by CVS/caremark to be appropriate, less the applicable co-payment.</td>
</tr>
<tr>
<td>Prescription filled that is rejected by CVS/caremark, but is subsequently approved pursuant to Fund’s Medical Director review.</td>
<td>Reimburse the amount determined by CVS/caremark to be appropriate, less the applicable co-payment.</td>
</tr>
<tr>
<td>Compound prescription filled that is rejected by CVS/caremark and subsequently approved pursuant to CVS/caremark review.</td>
<td>Reimburse the amount determined by CVS/caremark to be appropriate, less the applicable co-payment.</td>
</tr>
<tr>
<td>Prescription filled at a non-participating (Out-of-Network) pharmacy.</td>
<td>Reimburse the amount determined by CVS/caremark to be appropriate, less the applicable co-payment.</td>
</tr>
</tbody>
</table>

In order to receive reimbursement You must fill out a claim form and provide to the Fund a pharmacy receipt. You may obtain a claim form from your CVS/caremark Prescription Benefit Booklet, by contacting the Fund’s Member Services Call Center or from the Formspage of the Fund’s website.

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

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

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

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

**SEC. 13.7: CLAIMS FOR DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

In the event of a death or dismemberment, the Fund’s Member Services Call Center should be contacted for instructions on filing a claim for benefits. A representative will discuss the requirements, statements or other information needed to process the claim. All death benefits require submission of a certified death certificate along with a completed claim form when filing the claim.

**SEC. 13.8: CLAIM RECEIPT DEADLINE**

All claims for benefits must be received within fifteen months after the date the eligible expense is incurred (i.e. date the services were rendered) except that claims for weekly accident and sickness benefits and total and permanent disability benefits must be received within fifteen months after the Disability occurs, three years following the active Participant or Beneficiary and the Retiree or Retiree Spouse date of death or the Participant’s date of accidental death and dismemberment. If the Fund requests additional information from You or your provider with regard to your claim, the Fund must receive the response within 45 Days from the date of the request to respond.
The Fund’s Board of Trustees has full and absolute discretion, authority and power to interpret the terms of the MCTWF’s Actives Plan and MCTWF Retirees Plan, determine all questions of coverage and eligibility and adjudicate benefit claims. If your benefit claim is denied in whole or in part, you have the right to appeal.

SEC. 14.1 APPEAL PROCEDURE FOR MCTWF RETIREES PLAN

If you wish to appeal a benefit denial, you must submit the appeal in writing within 180 Days after you receive a denial of benefits. Appeals should be sent to the Appeals Department at the address below:

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

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

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

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

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

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

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

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

The request may be made orally, and the Fund will communicate with You by telephone,
faxsimile, or similarly rapid communication method.

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

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

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

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

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

**SEC. 14.2 APPEAL PROCEDURE FOR MCTWF ACTIVES PLAN**

If You need help understanding your Explanation of Benefits (“EOB”) that You receive for
every medical service provided to You or our decision to deny You a service or coverage,
contact the Funds’s Member Services Call Center at (313) 964-2400.

If You don’t agree with this decision You have a right to appeal any decision not to provide or
pay for an item or service (in whole or in part) by filing an appeal. You must submit the appeal
in writing within 180 Days after You receive a denial of benefits. To file an appeal complete a
Participant Benefit Claim Appeal form, and send it to: Michigan Conference of Teamsters Welfare
Fund, 2700 Trumbull Avenue, Detroit, MI 48216, Attention: Appeals Department. See also the “Other resources to help You” section below for assistance filing a request for an appeal.

If your situation is urgent and meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also by completing the Appeal Filing Form included at the bottom of every EOB you receive.

You or someone you name to act for you (your authorized representative) may file an appeal. You must complete an Individual Authorization to Release Protected Health Information naming your authorized representative. The form is available by contacting the Fund’s Member Services Call Center or on the Fund’s website at www.mctwf.org.

You may submit with your appeal written comments, documents or other information in support of your appeal.

You may request copies of information relevant to your claim free of charge. If you think a coding error may have caused your claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216, Attention: Member Services Department.

Once you file an appeal, the Fund review its decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For help about your rights, this notice, or for assistance, you can contact: the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact the Office of Financial and Insurance Regulation, HICAP, 611 W. Ottawa Street, Lansing, MI 48933, (877) 999-6442.
ERISA requires plan fiduciaries to use all reasonable means to recover benefits payments made to or on behalf of participants and Beneficiaries who were not eligible for such benefits. The Fund has the right and obligation to recover such overpayments from:

- any person to whom payments were made;
- any person for whom payments were made,
- any insurance company or organization to which payments were made, and
- directly from You.

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

If in the process of recovering an overpayment You are issued a final demand letter, You will have 21 Days to repay the full amount owed, otherwise coverage will be immediately suspended until such time as it is fully repaid. Eligibility to participate in any Fund self-contributory program, including the Retirees Plan or Retiree Death Benefit, will be immediately suspended. Once the overpayment is fully repaid, coverage will be retroactively reinstated.
When the Fund pays any benefits for You, it immediately gains all rights of recovery against any person or entity that caused or contributed to the loss Covered by it. This is called subrogation. Where reasonable cause exists to believe there may be another source from which to recover for the same loss, payment of benefits is conditioned upon the execution by You of the Fund’s Assignment, Subrogation and Reimbursement Agreement. You may be eligible to receive benefits under an Assignment, Subrogation and Reimbursement Agreement if your workers’ compensation claim is denied and You are appealing the ruling. All requests are reviewed on an individual basis. However, if your Beneficiary suffers a work related Accidental Injury or Illness and she has other insurance which is primary to your MCTWF Actives Plan or MCTWF Retirees Plan, no Assignment, Subrogation and Reimbursement Agreement will be offered.

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

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

You and those acting on your behalf, including attorneys -

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

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

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

The Fund is entitled to assignment, subrogation and reimbursement even if such amounts constitute only a partial recovery and are insufficient to compensate You for all damages sustained. The Fund is not required to participate in any damage claim or pay attorney’s fees to any attorney You hire to pursue the damage claim. This assignment, subrogation and reimbursement provision applies whether or not a third party admits liability for payment.
You may receive payment for medical services before benefits are paid under the Fund. In that case, the benefit payable by the Fund will be limited to the amount of benefits in excess of the amount already paid, if any. Such amounts include all direct or indirect payments to, or on behalf of, You for Accidental Injury or Illness from any source by settlement, judgment or any other means.

Once the injured party has permanently settled his claim with the responsible party by way of redemption order (or similar instrument), although pre-settlement claims continue to be deemed work related, post-settlement claims are deemed non-work related and are eligible for payment if the individual is actively covered under a Fund benefit package. If settlement is by way of a voluntary payment agreement (or similar instrument), not only do pre-settlement claims continue to be deemed work related, post-settlement claims continue to be deemed work related, post-settlement claims continue to be deemed work related unless such claims are time barred from being filed under the applicable state statute. If time-barred, the claims are treated as non-work related and will be eligible for payment if the individual is actively covered under a Fund benefit package.

In the event a Workers Compensation claim is deemed non-compensable by the decision of a Magistrate or any appeal thereof the Fund's work related exclusion ("...injury or Illness arising in the course of employment that is Covered under any workers’ compensation or occupational disease law or other state law or other insurance) would no longer apply, retroactive to the date of the said injury or illness.)
An individual who is entitled to receive benefits under an MCTWF Actives Plan and MCTWF Retirees Plan may also be eligible for similar benefits under another group health plan.

If you have coverage under another group health plan, as well as under the MCTWF Actives Plan and MCTWF Retirees Plan, benefits entitlement will be coordinated between the two plans.

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

The Primary Plan is the plan that pays benefits first and the Secondary Plan is the plan that pays those benefits not covered or not completely covered by the primary plan. When the patient is covered by one plan as an active employee and another plan as a spouse, or by one plan as an active employee, or the spouse thereof, and by another plan as a retiree, or the spouse thereof, the following coordination of benefits rules apply if both group health plans have a COB provision:

- The plan covering the patient as an active employee or as a retired employee is primary to any plan in which the patient is covered as the dependent spouse of an active or retired employee.
- The plan covering the patient as an active employee is primary to any plan in which the patient is covered as a retiree.
- The plan covering the patient as a dependent spouse of an active employee is primary to a plan in which the patient is covered as a dependent spouse of a retiree.

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 deemed the Primary Plan.

- For Dependent children -
  - The Plan of the parent whose birth date falls earlier in the calendar year is the Primary Plan when:
    > the parents are married;
    > the parents are living together (regardless of whether they ever have been married);
    > a court decree states both parents are responsible for the Dependent child’s health care expenses or health care coverage; or
    > a court decree awards joint custody but does not specify which parent is responsible for the Dependent child’s health care expenses or health care coverage.
  
  If both parents have the same birth date, the Plan that has covered the parent the longest is the Primary Plan.
  - If a court decree designates only one of the parents as responsible for the Dependent child’s health care expenses or health care coverage, that parent’s Plan is the Primary Plan. If that designated parent has no health care coverage but his Spouse does, that parent’s Spouse’s Plan is the Primary Plan.
  - If no court decree allocates responsibility for the child’s health care expenses or health care coverage, the order of coverage of plans is as follows:
    > first, the Plan covering the custodial parent;
    > second, the Plan covering the custodial parent’s Spouse;
    > third, the Plan covering the non-custodial parent; and
    > fourth, the Plan covering the non-custodial parent’s Spouse.
SEC. 17.1: COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

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

If the patient’s Primary Plan reduces benefits because of non-compliance with its specific provisions, the amount of that reduction will not be Covered under the MCTWF Actives Plan and MCTWF Retirees 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 the MCTWF Actives Plan or MCTWF Retirees Plan.

SEC. 17.2: COORDINATION WITH MEDICARE

Medicare provides coverage to people who:

• are age 65 and older (if your birthday is on the 1st day of any month, Medicare is effective the 1st day of the prior month and if it is on the 2nd day of the month or later, Medicare is effective on the 1st day of the current month);
• are totally disabled (Medicare is effective following 24 months of Social Security Disability benefits or the first month that Social Security disability benefits begin in the case of Amyotrophic Lateral Sclerosis); or
• have End Stage Renal Disease (ESRD).

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

In the case of MCTWF Actives Plan participation -

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

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

In the case of COBRA continuation coverage Plan participation -

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

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

For more information about Medicare benefits, contact your local Social Security Administration office, visit www.medicare.gov or call 1-800-MEDICARE.

SEC. 17.3: RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To the extent permitted by law, the Fund reserves the right to release or obtain any information about You to or from any insurance company, Hospital, Physician or other organization or individual to determine how benefits will be paid. In addition, if You are claiming benefits under the MCTWF Actives Plan or MCTWF Retirees Plan, You will be required to provide any necessary information to the Fund.
Your benefits under the MCTWF Actives Plan or MCTWF Retirees Plan may not be assigned by the Fund or seized to pay your debts unless -

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

This rule does not affect the Fund’s right to recover overpayments it made to You or on your behalf.
Health Insurance Portability and Accountability Act (HIPAA) - HIPAA is a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also gives the Federal Government the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and Employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

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

**SEC. 19.1: NOTICE OF PRIVACY PRACTICES**

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

**Your Rights**

You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for You
- File a complaint if You believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

**Our Uses and Disclosures**

We may use and share your information as we:
- Help manage the health care treatment You receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
19.1(a) YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a Copy of Health and Claims Records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to Correct Health and Claims Records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request Confidential Communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to Limit What we Use or Share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a List of those with Whom We’ve Shared Information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment, and health care operations, if available.

Get a Copy of this Privacy Notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose Someone to Act for You
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
File a Complaint if You Feel Your Rights are Violated

• You can complain if You feel we have violated your rights by contacting us using the information on page 83.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against You for filing a complaint.

19.1(b) YOUR CHOICES

For certain health information, You can tell us your choices about what we share. If You have a clear preference for how we share your information in the situations described below, talk to us. Tell us what You want us to do, and we will follow your instructions.

In these cases, You have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation
  If You are not able to tell us your preference, for example if You are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless You give us written permission:
• Marketing purposes
• Sale of your information

19.1(c) OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help Manage the Health Care Treatment You Receive
We can use your health information and share it with professionals who are treating You.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our Organization
• We can use and disclose your information to run our organization and contact You when necessary.
• We are not allowed to use genetic information to decide whether we will give You coverage and the price of that coverage. Example: We use health information about You to develop better services for You.

Pay for Your Health Services
We can use and disclose your health information as we pay for your health services. Example: We share information about You with your dental plan to coordinate payment for your dental work.

Administer Your Plan
We may disclose your health information to your health plan sponsor for plan administration.
How Else Can We Use or Share Your Health Information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with Public Health and Safety Issues
We can share health information about You for certain situations such as:
• Preventing disease.
• Helping with product recalls.
• Reporting adverse reactions to medications.
• Reporting suspected abuse, neglect, or domestic violence.
• Preventing or reducing a serious threat to anyone’s health or safety.

Do Research
We can use or share your information for health research.

Comply with the Law
We will share information about You if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director
• We can share health information about You with organ procurement organizations.
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers’ Compensation, Law Enforcement, and Other Government Requests
• We can use or share health information about You:
  • For workers’ compensation claims.
  • For law enforcement purposes or with a law enforcement official.
  • With health oversight agencies for activities authorized by law.
  • For special government functions such as military, national security, and presidential protective services.

Respond to Lawsuits and Legal Actions
How do we typically use or share your health information?

We can share health information about You in response to a court or administrative order, or in response to a subpoena.

We never share your health information for marketing purposes. We never sell You health information.

Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.
19.1(d) OUR RESPONSIBILITIES

• We are required by law to maintain the privacy and security of your protected health information.
• We will let You know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give You a copy of it.
• We will not use or share your information other than as described here unless You tell us we can in writing. If You tell us we can, You may change your mind at any time. Let us know in writing if You change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

19.1(e) CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about You. The new notice will be available upon request, on our web site, and we will mail a copy to You.
You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that You are entitled to -

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

You have the right to -

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and Union halls, all documents governing the MCTWF Actives Plan and MCTWF Retirees Plan. These include insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual report (Form 5500 Series) filed by the MCTWF Actives Plan and MCTWF Retirees Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the MCTWF Actives Plan and MCTWF Retirees Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest Annual report (Form 5500 Series) and updated SPD Booklet. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the MCTWF Actives Plan and MCTWF Retirees Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.

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

You also have the right to -

- Continue health care coverage for yourself if there is a loss of coverage under the MCTWF Actives Plan or MCTWF Retirees Plan as a result of a qualifying event. You may have to pay for such coverage. Review this SPD Booklet and the documents governing the MCTWF Actives Plan and MCTWF Retirees 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 MCTWF Actives Plan or MCTWF Retirees Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ceases.

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

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

In addition to creating rights for You, ERISA imposes duties upon the people who are responsible for the operation of the MCTWF Actives Plan and MCTWF Retirees Plan. The people who operate the MCTWF Actives Plan and MCTWF Retirees Plan, called “fiduciaries” of the MCTWF Actives Plan and MCTWF Retirees Plan, have a duty to do so prudently and in the interest of You and other MCTWF Actives Plan and MCTWF Retirees 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.

**SEC. 20.4: ENFORCE YOUR RIGHTS**

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

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

If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the MCTWF Actives Plan and MCTWF Retirees 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 the MCTWF Actives Plan and MCTWF Retirees Plan fiduciaries misuse the MCTWF Actives Plan and MCTWF Retirees Plan’s money, or if You are discriminated against for asserting your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds your claim is frivolous.

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

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

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

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

You may also find answers to the MCTWF Actives Plan and MCTWF Retirees Plan questions at the website of the EBSA at http://www.dol.gov/ebsa/. A list of EBSA field offices is located at http://www.dol.gov/ebsa/AboutEBSA/AboutEBSA/aboutEBSA.html#section13.
The following material provides information about how the MCTWF Actives Plan and MCTWF Retirees Plan are administered:

SEC. 21.1: PLANS’ NAME AND ADDRESS

MCTWF Actives Plan  
2700 Trumbull Avenue  
Detroit, Michigan 48216

MCTWF Retirees Plan  
2700 Trumbull Avenue  
Detroit, Michigan 48216

SEC. 21.2: PLANS’ SPONSOR

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

SEC. 21.3: EMPLOYER IDENTIFICATION NUMBER (EIN)

38-1328578

SEC. 21.4: PLANS’ NUMBERS

501 - MCTWF Actives Plan  
502 - MCTWF Retirees Plan

SEC. 21.5: TYPE OF WELFARE PLAN

The MCTWF Actives Plan provides medical, prescription drug, hearing, dental, vision, death, accidental death and dismemberment, weekly accident and sickness and total and permanent disability benefits.

The MCTWF Retirees Plan provides medical, prescription drug, hearing, dental, and death benefits.

SEC. 21.6: TYPE OF PLAN ADMINISTRATION

The MCTWF Actives Plan and the MCTWF Retirees Plan are self-administered.

SEC. 21.7: PLANS’ ADMINISTRATOR

Board of Trustees, Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, Michigan 48216  
(313) 964-2400  
(800) 572-7687
SEC. 21.8: PLANS’ TRUSTEES

The following individuals are the Board of Trustees for the MCTWF Actives Plan and the MCTWF Retirees Plan:

**Union Trustees:**
- H.R. Hillard
- Ronald E. Holzgen
- Kevin D. Moore
- Paul M. Kozicki

**Employer Trustees:**
- Raymond J. Buratto
- Earl D. Ishbia
- Robert W. Jones
- José C. Rosario

The mailing address for each Trustee is:
- Michigan Conference of Teamsters Welfare Fund
  2700 Trumbull Avenue
  Detroit, Michigan 48216

SEC. 21.9: COLLECTIVE BARGAINING AGREEMENTS

The MCTWF Actives Plan and the MCTWF Retirees Plan are maintained according to a number of Collective Bargaining Agreements. You may obtain a copy of your Collective Bargaining Agreement upon request to the Plan Administrator, and is available for examination by Participants and Beneficiaries at the Fund office.

SEC. 21.10: SOURCES OF CONTRIBUTIONS TO THE PLANS

Employer contributions are made to the Michigan Conference of Teamsters Welfare Fund according to the terms of applicable Collective Bargaining Agreements or Participation Agreements. These contributions are allocated between the MCTWF Actives Plan and the MCTWF Retirees Plan in accordance with their respective Contribution rates. Retiree self-contributions are made to the Michigan Conference of Teamsters Welfare Fund and allocated to the MCTWF Retirees Plan. In certain circumstances, Employee Contributions may be made to the Michigan Conference of Teamsters Welfare Fund; these are allocated to the MCTWF Actives Plan.

SEC. 21.11: FUNDING

The MCTWF Actives Plan and the MCTWF Retirees Plans are funded by Contributions as provided in Sec. 21.10 hereof and from earnings from MCTWF Actives Plan and the MCTWF Retirees Plan investments, respectively.

SEC. 21.12: PLAN YEAR

The Plan Year for both the MCTWF Actives Plan and the MCTWF Retirees Plan begins on April 1st and continues through March 31st.

SEC. 21.13: AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the MCTWF Actives Plan or the MCTWF Retirees Plan, service of legal process may be made on the Executive Director, Plan Administrator, or any individual Trustee at 2700 Trumbull Avenue, Detroit, Michigan 48216.
SEC. 21.14: ADMINISTRATIVE SERVICES

Blue Cross Blue Shield of Michigan (BCBSM), Delta Dental of Michigan, CVS/caremark and Davis Vision provide certain administrative services under the MCTWF Actives Plan and the MCTWF Retirees Plan. Their addresses are:

Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
Detroit, Michigan 48226

Delta Dental of Michigan
4100 Okemos Road
Okemos, Michigan 48864

CVS/caremark
2211 Sanders Road
Northbrook, Illinois 60062

Davis Vision
711 Troy Schenectady Road
Latham, NY 12110

BCBSM, Delta Dental of Michigan, CVS/caremark and Davis Vision are not authorized to make final benefit claim decisions under the MCTWF Actives Plan or MCTWF Retirees Plan. Questions concerning claims or benefits under the MCTWF Actives Plan or MCTWF Retirees Plan should be sent to the Fund.

21.14(a) EMPLOYMENT RIGHTS NOT GUARANTEED

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

21.14(b) AMENDMENT OR TERMINATION OF PLANS

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

Amendments to or termination of the MCTWF Actives Plan and MCTWF Retirees Plan can be made at any time and for any reason. In the event of elimination, reduction or modification of benefits, You or your beneficiary may be required to pay for benefits that were formerly covered by the MCTWF Actives Plan and MCTWF Retirees Plan.

21.14(c) MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND TERMINATION

The Michigan Conference of Teamsters Welfare Fund may be terminated at any time and for any reason. In such event, the Trustees will take necessary steps to wind down the Trust. In conformity with the provisions of the Trust Agreement, the Trustees will apply the MCTWF Actives Plan and MCTWF Retirees Plan assets to pay or to provide for the payment of all obligations of the MCTWF Actives Plan and MCTWF Retirees Plan respectively. Any remaining MCTWF Actives Plan and MCTWF Retirees Plan 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 Trust, subject to the requirement that no part of the assets of the Trust be diverted to any purpose other than the exclusive benefit of Participants and Beneficiaries and payment of the administrative expenses of the MCTWF Actives Plan and MCTWF Retirees Plan respectively. Upon termination, no part of the assets of MCTWF Actives Plan and MCTWF Retirees Plan, respectively, 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 Michigan Conference of Teamsters Welfare Fund including, but not limited to, the terms of the MCTWF Actives Plan and MCTWF Retirees Plan benefits, rules, regulations and policies adopted by the Trustees, or to alter, amend or terminate the MCTWF Actives Plan or MCTWF Retirees Plan.

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

• all questions regarding the MCTWF Actives Plan or MCTWF Retirees Plan coverage and eligibility;
• methods of providing benefits;
• all matters concerning the operation of the MCTWF Actives Plan and the MCTWF Retirees Plan; and
• all claims for benefits.

Benefits under the MCTWF Actives Plan or MCTWF Retirees Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.
The following are definitions of specific words and terms used in this SPD Booklet:

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

**Accidental Injury** means any disabling disorder of the body or mind that is the direct result of an occurrence that is not a sickness.

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

**Adult Dependent Child** means one who is between the age of 19 and the end of the month in which he turns 26.

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

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

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

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

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

**Beneficiary** means a person who is -
- the Participant's Spouse recognized as a Spouse under the law of any State of the United States.
- the Participant's natural or step child, or child who has been placed with him for adoption, or whom he has adopted, through the end of his 26th birthday month;
- the Participant's natural or step child, or child who has been placed with him for adoption, or whom he has adopted, regardless of age (except that such child over the age of 26 must be unmarried), who has been determined by a Physician, psychologist or psychiatrist to be Totally and Permanently Disabled.

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

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

**Collective Bargaining Agreement** means the negotiated labor agreement between your bargaining representative and your Employer.
**Copayment** means the flat dollar amount You are responsible for paying when You receive medical services or obtain prescription drugs and may depend on whether services are provided by a Network or Out-of-Network provider.

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

**Contributions** mean payments made to the Fund by an Employee, Contributing Employer, Retiree or parent of a Dependent child pursuant to a Qualified Medical Child Support Order.

**Covered** means eligible to receive MCTWF Actives Plan or MCTWF Retirees Plan benefits.

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

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

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

**Dependent** means a person who is -
- the Participant’s natural or step child, or child who has been placed with him for adoption, or whom he has adopted, through the end of his 26th birthday month;
- the Participant’s natural or step child, or child who has been placed with him for adoption, or whom he has adopted, regardless of age (except that such child over the age of 26 must be unmarried), who has been determined by a Physician, psychologist or psychiatrist to be Totally and Permanently Disabled.

**Disability** means the inability to perform the regular duties of employment because of a non-occupational or non-auto-related Accident or Sickness, or due to pregnancy.

**Doctor or Physician** means one who is licensed to practice as a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.) or an Oral Surgeon.

**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 Accidental Injury or Illness; and
- is not disposable or non-durable.
**Employee** means a person for whom an Employer is obligated to make Contributions to the Fund under a Collective Bargaining Agreement or Fund Participation Agreement.

**Employer, Contributing Employer or Participating Employer** means any firm, association, partnership or corporation that is obligated to make Contributions to the Fund pursuant to the terms of a Collective Bargaining Agreement and/or Fund Participation Agreement.

**Experimental or Investigative** refers to care, treatments, services, procedures or supplies that are not yet recognized as accepted medical practice by the general medical community in the state where the services are provided, or devices or drugs that have not yet received required governmental approval. This includes, but is not limited to, trial procedures or protocols performed on a minimal number of patients to establish data for a rate of cure or improvement in the quality of life, and care, treatment, services and supplies not considered reasonable and customary by any government agency or subdivision, including as provided in the CMS Medicare Coverage Issues Manual.

**Extended Retiree Spouse** means the Spouse of a former MCTWF Retirees Plan Participant who has exhausted her right to obtain MCTWF Retirees Plan coverage at the Retiree self- Contribution rate and who is now participating in the MCTWF Retirees Plan at the cost-based rate.

**Family Medical Leave** means absence from work pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA).

**Fund** means the Michigan Conference of Teamsters Welfare Fund.

**Generic Drug** means a prescription drug which is produced and distributed without patent protection. Generic Drugs must contain the same active ingredients as their Brand Name Drug counterparts. Generic Drugs are considered by the Food and Drug Administration as identical in dose, strength, route of administration, safety, efficacy and intended use as their Brand Name Drug counterparts.

**Hospital** means an institution that -
- is accredited by The Joint Commission;
- is eligible to participate in and to receive payments in accordance with the provisions of Medicare; or
- meets all of the following requirements:
  - provides, on an inpatient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of doctors licensed to practice medicine;
  - provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses; and
  - is operated continuously with organized facilities for operative surgery on the premises.

**Illness** means any disabling disorder of the body or mind (other than Accidental Injury) and pregnancy (including abortion, miscarriage, or childbirth).

**Local Union** means those Local Unions affiliated with the International Brotherhood of Teamsters.
**Maximum Allowable Benefit (MAB)** means the MCTWF Actives Plan and MCTWF Retirees Plan's allowable portion of the Amount Billed by a provider that does not participate in the BCBS, Delta Dental of Michigan or Davis Vision, subject to Deductible, Copayment and Coinsurance amounts.

**MCTWF Actives Plan or MCTWF Retirees Plan** means a group health plan administered according to rules described in this Booklet and in any other written documents that the Trustees designate under the terms of the Trust Agreement.

**Medical Attention** means under the regular care of a qualified healthcare provider.

**Medically Necessary** means those services, treatments or supplies provided to You by a Hospital or healthcare professional, which services are required, in the judgment of the Trustees, to identify or treat a condition, disease, Accidental Injury or Illness and -
- are consistent with the symptoms, diagnosis or treatment of the condition, disease, Accidental Injury or Illness;
- are appropriate according to acceptable standards of good medical practice;
- are not solely for the convenience of You, the Hospital or the healthcare professional;
- are the most appropriate that can be safely provided to You under the circumstances; and
- are not Experimental or Investigative in nature.

**Medicare** means the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965 (Public Law 89-87), as this Program is currently constituted and as it later may be amended.

**Months** mean units of time, measured from the date of a given event and ending on a date, that number of months later, one calendar day prior.

**Network** means a group of Hospitals and/or healthcare professionals who are bound by contract to certain standards of conduct and fee schedules as payment in full (excluding any applicable Deductible, Copayment and Coinsurance amounts) for healthcare services.

**Non-preferred Brand Name Drug** means a prescription drug that has a generic equivalent and/or therapeutic alternative and has been deemed by the pharmacy benefit manager to be equal to or less effective than the preferred brand therapeutic alternative(s) and excessively costly.

**Out-of-Network** means those Hospitals and/or healthcare professionals that are not in the Network and therefore may charge, without limitation, for their services.

**Out-of-Pocket Maximum** means the amount of money that You will have to spend for Coinsurance charges during each calendar year and is based on whether your medical services are provided by a Network or Out-of-Network provider.

**Participant** means Employee or Retiree.

**Participation Agreement** means a written agreement signed by an Employer pursuant to which the Employer contributes to the Fund.
Primary Plan means the Plan that pays benefits first when more than one group health plan provides coverage to You.

Prohibited Employment means (a) employment, by an Employer, in any position, or (b) employment, other than government employment, in a position Covered by a Collective Bargaining Agreement between the Employer and any affiliate of the International Brotherhood of Teamsters, or (c) employment (including but not limited to self-employment), other than government employment, in the same industry in which the former Employee was an Active Employee Covered by the Fund.

Retirement Date means the date an Employee ceases to be Covered by the Fund as an Active Employee as a result of retirement, after application of all remaining benefit bank weeks. In certain circumstances, the purchase of COBRA continuation coverage may extend the Employee’s Retirement Date until the cessation of such coverage (see Sec. 2.2(f), COBRA Continuation Coverage Contributions).

Retiree means a former Employee of an Employer that made Contributions to the Fund under the terms of a Collective Bargaining Agreement or under a Fund Participation Agreement, who meets the requirements for enrollment in MCTWF’s Retirees Plan.

Schedule of Benefits means the document that describes the specific benefits that comprise an MCTWF Actives Plan or MCTWF Retirees Plan benefit package and how those benefits are administered. The Schedule of Benefits is one component of the Summary Plan Description.

Seasonal Work means work that is performed only during certain seasons.

Secondary Plan means the Plan that pays benefits not Covered or not completely Covered by the Primary Plan when more than one group health plan provides coverage to You.

Sickness means any disabling disorder of the body or mind (other than Accidental Injury) and pregnancy (including abortion, miscarriage, or childbirth).

Skilled Nursing Facility means an institution, or distinct part of an institution, that -
• has in effect a transfer agreement with one or more Hospitals;
• is primarily engaged in providing inpatient skilled nursing care;
• is duly licensed;
• has one or more Physicians and one or more registered professional nurses responsible for patient care;
• requires that patients be under the care of a Physician;
• maintains clinical records for all patients;
• provides 24-hour-a-day nursing services;
• provides procedures to dispense drugs and medications;
• has a utilization review plan in effect;
• is eligible to participate in Medicare; and
• is not an institution that primarily covers the care and treatment of mental diseases or tuberculosis.
Spouse means an individual recognized as a Spouse of the Participant under the law of any State of the United States.

Summary Plan Description (SPD) means this Booklet, the Schedule of Benefits, and any material modifications thereof as published in the Fund’s newsletter, the Messenger.

Telehealth Services or Telemedicine means on demand access to consultations with physicians and licensed therapists by secure video, telephone or email.

Total and Permanent Disability (TPD) or Totally and Permanently Disabled means a determination by the Trustees that You have a physical or mental condition that is expected to continue for the remainder of your life and that causes You to be unable to engage in any regular employment or occupation for compensation, profit or gain for which You may be suited by your education, training or experience.

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

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

Union means the International Brotherhood of Teamsters.

Year means a period of 365 Days.

You means the Participant and his eligible Beneficiaries.
Michigan Conference of
Teamsters Welfare Fund
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Detroit, Michigan 48216
(313) 964-2400 or (800) 572-7687
www.mctwf.org