Compilation of Messenger Notifications
Fall 2012 through Fall 2013

The *Messenger* is a publication that is used to notify you of changes to your plan of benefits. Such notifications, in combination with your Summary Plan Description (SPD) booklet and Schedule of Benefits, form your complete SPD. Attached you will find a compilation of Messenger notifications from the Fall 2012 issue through the Fall 2013 issue, arranged chronologically by topic. It is vital that you read all notifications within a topic to ensure that you are aware of the latest change. Your SPD will continue to be updated by new issues of the *Messenger.*

November 2013
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ELIGIBILITY

Dependent Children and Spouses – Spring 2013

For the purpose of determining eligibility under the MCTWF’s plans of benefits, the Summary Plan Description (subject to additional criteria) defines a dependent as including a participant’s children and spouse. In order to conform to the definition of “dependents” under the Affordable Care Act, as recently determined by the U.S. Department of the Treasury, which limits “dependents” to children age 26 and below, MCTWF has removed the spouse from its definition of “dependent” and hereafter will refer separately to a participant’s covered dependents and spouse, or together as the participant’s “beneficiaries.”

Benefit Bank Weeks Entitlement for New Participants – Fall 2013

Currently, employees of newly participating employers do not become entitled to benefit bank weeks until contributions have been made on their behalves for 12 consecutive weeks, or 13 out of 17 weeks, whereas new employees of already participating employers become entitled to benefit bank weeks once contributions commence on their behalves.

Effective January 1, 2014, employees of newly participating employers and newly hired employees of already participating employers will become entitled to benefit bank weeks once contributions have been made on their behalves for 8 consecutive weeks, or 9 out of 13 weeks.

Benefit Bank Weeks Included in COBRA Coverage – Fall 2013

Effective April 1, 2012, dental and optical benefits were restored to benefit bank weeks (for those who had dental and optical benefits while actively employed). This is to clarify that effective April 1, 2012 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.

Adult Dependent Children Up to Age 26 New Open Enrollment Window – Fall 2013

In accordance with the Affordable Care Act, MCTWF has made coverage available to all dependent adult children through the end of their 26th birthday month. The temporary exception to this rule is that adult dependent children are not entitled to coverage if they are eligible to enroll in an employer sponsored health plan, other than that of their parents. This exception ends upon the earlier of April 1, 2014 or the cessation of the “grandfathered” status of the participant/parent’s MCTWF health plan. Except for those children who already were covered or became covered under MCTWF’s rules on or after February 27, 2011, eligibility for coverage on or after April 1, 2011 has been contingent upon submission to MCTWF of an Adult Child Coverage Application for Enrollment form during an authorized enrollment period. There have been three such enrollment periods; January to February 2011, November to December 2011, and November to December 2012.

Despite our several efforts to communicate the enrollment requirements to affected participants and their eligible children, a few affected adult children still have failed to submit a timely Application. Accordingly, the Trustees have authorized another enrollment period for those adult children, beginning November 1, 2013 and ending December 16, 2013, to permit eligibility for coverage commencing on or after January 1, 2014 (contingent upon the eligibility of the child’s parent/participant and only if the child’s age is less than 26 at that time).

To enroll, an Adult Child Coverage Application for Enrollment form must be fully filled out and received by MCTWF between November 1, 2013 and December 16, 2013. This form is available on the Forms page of MCTWF’s website at www.mctwf.org, or by contacting MCTWF’s Customer Communications Department. Please note that the Application must be timely submitted - (a) regardless of whether the adult child’s participant/parent is eligible for coverage at the time of submission of the Application. If and when that participant/parent resumes covered employment, the adult child’s eligibility will commence; or (b) regardless of whether the adult child is excluded from MCTWF coverage by virtue of his eligibility to enroll in an employer sponsored health plan, other than that of his parents. In such case, the adult child’s eligibility will commence on the earlier of April 1, 2014 or the date upon which his participant/parent’s MCTWF health plan ceases to be “grandfathered” under the Affordable Care Act.
MEDICAL BENEFITS – ACTIVE & RETIREE PLANS

Provider Networks Change For Mental Health and Substance Use Disorder Benefits–Spring 2013

Effective April 1, 2013, Blue Cross Blue Shield’s PPO nationwide provider network will replace ValueOptions as MCTWF’s mental health and substance use disorder provider network.

With this network change, outpatient services will no longer require prior authorization. However, providers must continue to receive prior authorization for 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) by contacting Blue Cross Blue Shield at 800-762-2382, Monday through Friday 8:30 a.m. to 11:30 a.m. and 12:30 p.m. to 5:00 p.m.

To determine whether a mental health or substance use disorder provider participates in the Blue Cross Blue Shield PPO network, you can link to the Blue Cross Blue Shield PPO provider search available on the Provider Networks page of MCTWF’s website at www.mctwf.org and click on the Blue Cross Blue Shield Michigan or non-Michigan Physician, Hospital and Facilities search, or you can contact MCTWF’s Customer Communications Department at 800-572-7687. For referrals after business hours, please contact Blue Cross Blue Shield at 800-810-BLUE (2583).

While the Blue Cross Blue Shield PPO network is extensive, not all ValueOptions outpatient network providers participate in it. To help facilitate the transition for those who are receiving ongoing authorized outpatient services after March 31, 2013 from a ValueOptions provider who does not participate in the Blue Cross Blue Shield PPO network, MCTWF will treat such services as “in-network” for patient copay or coinsurance purposes, until the earlier of July 1, 2013 or the exhaustion of the ValueOptions authorization. Please note, however, that you may be subject to balance billing if your ValueOptions provider does not accept MCTWF’s new “in-network” reimbursement amount (plus your copay or coinsurance amount) as payment in full. Accordingly, should you seek outpatient services between now and April 1, 2013, we encourage you to select a provider who participates in both the ValueOptions and Blue Cross Blue Shield PPO networks. We have sent letters with the foregoing information to all individuals whom we believe to be receiving outpatient services currently. Copay/coinsurance amounts will remain at the “in-network” level for all authorized inpatient services rendered by ValueOptions providers and the patient will have no exposure to balance billing.

In mid to late March, you will receive in separate mailings new BCBS ID Cards and MCTWF Network cards, which will provide the appropriate billing and prior authorization information needed for mental health and substance use disorder services. Your BCBS ID Card should be presented when utilizing any provider for mental health or substance use disorder services on or after April 1, 2013.

Compliance with Mental Health Parity and Addiction Equity Act – Spring 2013

Effective April 1, 2013 in accordance with the Mental Health Parity and Addiction Equity Act, mental health and substance use disorders must be covered with treatment limitations that are no more restrictive and at levels that are no lower than that would be the case for other medical benefits offered by a healthcare plan. Accordingly, all MCTWF Plan mental health and substance use disorder benefits outpatient and inpatient visit limits and all inpatient day limits will be eliminated. And with regard to coverage level for all Plans –

- For inpatient hospital services - coverage level is unchanged whether in-network or out-of-network.
- For inpatient professional visits - coverage level is unchanged if in-network; is changed to the medical benefit level if out-of-network (for example, coverage is increased from 50% of Maximum Allowable Benefits to 60%; or, in other words, coinsurance charges are reduced from 50% to 40%).
- For outpatient professional visits - coverage level is changed to the medical benefit level. All outpatient professional visits will be considered as primary care for copay determinations.

Applied Behavior Analysis Coverage – Spring 2013

Effective October 30, 2012, eligible MCTWF participants and beneficiaries diagnosed with an autism spectrum disorder are covered by their medical benefits for applied behavior analysis services under certain conditions.
Autism spectrum disorders are neurobiological conditions which include Autistic disorder, Asperger’s disorder and other pervasive developmental disorders. While MCTWF had covered a range of services to treat autism spectrum disorders, including physical, speech and occupational therapy, nutritional counseling and other mental health services, it had not covered applied behavior analysis to diagnose and treat autism spectrum disorders. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to provide significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

The conditions which must be satisfied for coverage of applied behavior analysis services for those diagnosed with autism spectrum disorder are –

- Confirmation of the autism spectrum disorder diagnosis by a Blue Cross Blue Shield of Michigan approved autism evaluation center. A list of approved autism evaluation centers can be found on the Info Links page of MCTWF’s website at www.mctwf.org;
- The provision by an approved autism evaluation center of a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for applied behavior analysis services; and
- The applied behavior analysis is provided by a board certified behavior analyst, subject to prior authorization. A list of applied behavior analysts can be found on the Info Links page of MCTWF’s website at www.mctwf.org.

Applied Behavior Analysis services are subject to the following annual limits based on the patient’s age on January 1st of each year:

- $50,000 through age 6
- $40,000 through age 12
- $30,000 through age 18

Appropriate Use of Emergency Room – Spring 2013

Emergency room utilization by MCTWF participants and beneficiaries is about 50% higher than the average utilization throughout the country as reported to MCTWF by its benefits consulting firm, Towers Watson. Emergency room services are far more expensive than comparable services rendered in a physician’s office or urgent care facility and should be used only when the need for emergency services is real and otherwise unavailable. MCTWF’s extraordinary emergency room claim experience is not only driven by occasional indiscriminate usage by many participants and beneficiaries, but in large part by chronic users; mostly about a half dozen times per year and some with several dozen emergency room visits per year.

Accordingly, as a first step in curbing inappropriate usage, MCTWF’s Medical Director is carefully reviewing for medical necessity all emergency room claims incurred by individuals in excess of three per 12 month period. If the use of the emergency room is determined to not have been medically necessary, the individual will bear the full cost of the billed services.

All participants and beneficiaries are urged to consider whether their medical condition warrants emergency room attention (please consult your Summary Plan Description booklet), or whether it can be addressed appropriately by their physician or by a local urgent care facility.

Required Notices of Waiver from the Annual Limit Requirement of the Affordable Care Act – Spring 2013

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This calendar year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $2 million.

Your health coverage, offered by the Michigan Conference of Teamsters Welfare Fund’s Retiree Medical Program Plans 145 and 475 and Freight Industry “Daily Rate” Mini-Med Plan 330, do not meet the minimum standards required by the Affordable Care Act described above. Your Retiree Medical Program Plans’ coverage have annual limits of $220,000 on all covered medical benefits and your Mini-Med Plan has an annual limit of $100,000.

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, under your Retiree Medical Program Plans 145 and 475, your insurance would only pay for 119 days, and under your Freight Industry “Daily Rate” Mini-Med Plan 330, your insurance would only pay for 54 days.
Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $2 million this calendar year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until March 31, 2014.

If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Michigan Conference of Teamsters Welfare Fund Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. In addition, you can contact the Michigan Health Insurance Consumer Assistance Program (HICAP) which is run by the Michigan Office of Financial and Insurance Regulation at:

611 W. Ottawa Street
Lansing, MI 48933
(877) 999-6442
http://michigan.gov/ofir (website)
OFIR-HICAP@michigan.gov (email)


Effective April 2013, the monthly self-contribution rates listed below apply to all those participating in MCTWF’s basic Retiree Medical Program, Plan 145. For those purchasing Plan 475, which includes the Retiree Supplemental Benefits Rider (MCTWF’s hearing, vision, and Dental Plan 2 benefits), add $128.50 to the following Plan 145 monthly rates:

<table>
<thead>
<tr>
<th>Age at MCTWF Retirement Date</th>
<th>Years Participating in MCTWF under a Plan with Retiree Medical Program Coverage</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>5 – 9</td>
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<tr>
<td>50 – 54</td>
<td>$750</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$755</td>
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<tr>
<td>60 – 64</td>
<td>$415</td>
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</tbody>
</table>

For eligible retirees whose active employment ceased prior to January 1, 2002: $345

To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing 45 days prior to the calendar month for which the Rider coverage is to terminate. For example, to drop coverage as of January 1st, MCTWF must receive written notification by November 15th. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

* Eligibility to participate in the Program ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate in the Program at the retiree self-contribution rate until or unless such participation, from the date of commencement, exceeds eight years. Spouse participation then requires self-contribution at the Program’s cost based rates. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the Program at the retiree’s contribution rate, unless or until the later of a) eight years from the date that the retiree’s Program coverage began or b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Program’s cost based rate as an “Extended Retiree Spouse.”

“Grandfathered” Status Under The Affordable Care Act - Spring 2013

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as “New SOA”, “New Key”*, “New I&S” or “New PEP” are “grandfathered plans” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the MCTWF Plan Administrator at 2700 Trumbull Avenue, Detroit, Michigan 48216. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, and 4

**Required Notice of “Grandfathered” Status Under The Affordable Care Act - Fall 2013**

Please be advised that this group health plan, the Michigan Conference of Teamsters Welfare Fund (MCTWF), believes that all current MCTWF medical plans not designated as “New SOA”, “New Key”*, “New I&S” or “New PEP” are “grandfathered plans” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act for example, the elimination of lifetime limits on benefits.

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* New Key Plans 1, 1a, 1b, 2, 2a, 2b, 2c, 2d, 3, and 4

**Emergency Ambulance Benefits - Fall 2013**

Under all MCTWF medical benefit plans, eligible in-network and out-of-network expenses are 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. Effective April 9, 2013, MCTWF’s coverage was broadened to hold harmless from out-of-network balance billing exposure, participants and beneficiaries who, in seeking emergency ambulance services, receive services from a non-participating ambulance provider, when no other reasonable choice is available.

**Emergency Room Benefits - Fall 2013**

As was announced in the spring 2013 Messenger, emergency room utilization by MCTWF participants and beneficiaries is about 50% higher than the average utilization throughout the country as reported to MCTWF by its benefits consulting firm, Towers Watson. As a result, MCTWF’s Medical Director reviews carefully for medical necessity all emergency room claims incurred by individuals in excess of three per 12 month period. Should the use of the emergency room be determined to not have been medically necessary, the individual will bear the full cost of the billed services.

All participants and beneficiaries are urged to consider whether their medical condition warrants emergency room attention. The Trustees have restated with examples the criteria that must be satisfied to qualify for emergency room benefits, as follows:

An emergency situation is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm.

Some examples of emergency illness are heart attack, stroke, loss of consciousness and convulsions.

Some examples of emergency 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.

We urge you, when possible, before deciding to go to an emergency room, to contact your primary care provider. If you have an unexpected medical problem requiring prompt attention that is not a true emergency as defined above, treatment should be sought from an urgent care facility.
**Immunizations - Fall 2013**

Immunizations received in accordance with MCTWF’s approved schedules (which follow the recommendations of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices) are covered, subject to applicable limits, by all MCTWF medical plans. For children, all immunizations are covered in full if received from a network provider. For adults, coverage is subject to applicable limits (please refer to your schedule of benefits for specifics). Below are the 2013 Child and Adolescent Immunization Schedule and the 2013 Adult Immunization Schedules. The Centers for Disease Control and Prevention publish these schedules together with footnotes (which are too voluminous to print here) that must be read in conjunction with the schedules. Please refer online to the complete schedule and footnotes, as noted beneath the schedules below or on the Info Links page of our website at www.mctwf.org.

### 2013 Child and Adolescent Immunization Schedule

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16-18 yrs</th>
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<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td></td>
<td>Dose 1</td>
<td>Dose 2</td>
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<td>Rotavirus (RV)</td>
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<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
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<td>Diphtheria, Tetanus, &amp; acellular Pertussis (DTaP))</td>
<td></td>
<td>Dose 1</td>
<td>Dose 2</td>
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<td>Dose 4</td>
<td>Dose 5</td>
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<td>Tetanus, diphtheria &amp; acellular pertussis (Tdap)</td>
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<td>Haemophilus Influenzae Type b (Hib)</td>
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<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
<td>Dose 3 or 4</td>
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<td>Pneumococcal conjugate (PCV13)</td>
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<td>Dose 1</td>
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<td>Dose 4</td>
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<td>Inactivated Poliovirus (IPV)</td>
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<td>Dose 1</td>
<td>Dose 2</td>
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<td>Influenza (IV, LAIV)</td>
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<td>Measles, Mumps, Rubella (MMR)</td>
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<td>Varicella (VAR)</td>
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<td>Hepatitis A (HepA)</td>
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<tr>
<td>Human Papillomavirus (HPV: females only; HPV4: males and females)</td>
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<td>Meningococcal</td>
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</tbody>
</table>

| Range of recommended ages for all children | Range of recommended ages for catch-up immunization | Range of recommended ages for certain high-risk groups | Range of recommended ages during which catch up is encouraged and for certain high-risk groups | Not Routinely recommended |

Please refer online to http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf
2013 Adult Immunization Schedule Based on Age Groups

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>19-21 Years</th>
<th>22-26 Years</th>
<th>27-49 Years</th>
<th>50-59 Years</th>
<th>60-64 Years</th>
<th>65 Years and Older</th>
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</thead>
<tbody>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose annually</td>
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<tr>
<td>Tetanus diphtheria pertussis (Td/Tdap)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 years</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 doses</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 or more doses</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2013 Adult Immunization Schedule Based on Medical and Other Indications

<table>
<thead>
<tr>
<th>VACCINE ↓  INDICATION →</th>
<th>Pregnancy</th>
<th>Immuno-compromising conditions (excluding human immunodeficiency virus (HIV))</th>
<th>HIV Infection CD4+ T lymphocyte count</th>
<th>Men who have sex with men (MSM)</th>
<th>Heart disease, chronic lung disease, chronic alcoholism</th>
<th>Asplenia (including elective splenectomy and persistent complement deficiencies)</th>
<th>Chronic liver disease</th>
<th>Kidney failure, end-stage renal disease, receipt of hemodialysis</th>
<th>Diabetes</th>
<th>Healthcare personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td></td>
<td>1 dose IIV annually</td>
<td>1 dose IIV or LAIV annually</td>
<td>1 dose IIV annually</td>
<td></td>
<td>1 dose IIV annually</td>
<td>1 dose IIV or LAIV annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
<td>1 dose Tdap each pregnancy</td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs</td>
<td>2 doses</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 21 yrs</td>
<td>1 dose</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>Contraindicated</td>
<td>2 doses</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 21 yrs</td>
<td>1 dose</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 21 yrs</td>
<td>1 dose</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 26 yrs</td>
<td>3 doses through age 21 yrs</td>
<td>1 dose</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster</td>
<td>Contraindicated</td>
<td>1 dose</td>
<td>1 dose</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>Contraindicated</td>
<td>1 dose</td>
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<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
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<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>1 or 2 doses</td>
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<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
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<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td>1 or 2 doses</td>
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<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
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<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td>2 doses</td>
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<td>2 doses</td>
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<tr>
<td>Hepatitis B</td>
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<td></td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

For persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

WEEKLY ACCIDENT AND SICKNESS BENEFITS

Short-Term Disabilities – Spring 2013

Participants who suffer a non-occupational, or non-auto related accident or sickness, and who otherwise meet MCTWF’s requirements, are entitled to ongoing coverage for themselves and their beneficiaries in accordance with the terms of their medical plan of benefits. The duration of such ongoing full plan coverage may be only for the period of additional employer contributions required by the participant’s collective bargaining agreement (but, in accordance with MCTWF’s rules, not less
than four weeks) or, if their benefit plan includes Weekly Accident & Sickness benefits, then up to a maximum of 26 weeks of disability.

MCTWF’s Trustees have resolved that for nonoccupational and non-auto related disabilities that commenced (in accordance with MCTWF’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 the participant’s plan provides for Weekly Accident & Sickness benefits. Thereafter, such ongoing full plan coverage beyond the period of additional employer contribution, up to a maximum duration of 26 weeks of disability, will be limited to participants whose plan includes Weekly Accident & Sickness benefits.

Weekly Accident and Sickness Benefits – Fall 2013

Participants who suffer a non-occupational, or non-auto related accident or sickness, and who otherwise meet MCTWF’s requirements, are entitled to ongoing coverage for themselves and their eligible beneficiaries in accordance with the terms of their schedule of benefits. Weekly accident and sickness benefits are not payable if the disability commences during a period of time the participant would not otherwise be working if the disability had not occurred. Your Summary Plan Description provides as an example, that if a disability occurs during a layoff, weekly accident and sickness benefits are not payable. MCTWF’s Trustees have determined that other such examples are when a participant is not working due to a personal leave or temporary work stoppage (e.g., strikes and lockouts).

Additionally, Weekly Accident and Sickness benefits entitlement is conditioned, in part, upon a determination of disability by a physician. The Trustees have resolved that effective January 1, 2014, physicians who are authorized to make such determination under a MCTWF plan of benefits 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. Accordingly, effective January 1, 2014, MCTWF no longer will accept a determination of disability by a chiropractor (D.C.).

PRESCRIPTION DRUG BENEFITS

New CVS Caremark Programs– Spring 2013

In an effort to assist participants in improving their health and safety as well as reducing costs, the following CVS Caremark programs were implemented as part of MCTWF’s prescription drug program for prescriptions filled on or after January 1, 2013:

Specialty Preferred Drug Program

If you are newly prescribed a “non-preferred” specialty medication for certain autoimmune diseases (rheumatoid arthritis, crohn’s disease or psoriasis) or for multiple sclerosis, the program requires that you be treated with the most common clinically effective medication. 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. Specialty medications are sent to you by mail. If you go to a retail pharmacy, the pharmacist will ask you to contact CVS Caremark at 800-237-2767 to initiate the direct relationship with Specialty Pharmacy Services. CVS Caremark will communicate directly with your prescribing physician regarding your treatment plan.

Pharmacy Advisor Support Program

If you are taking medications for any of the following chronic conditions and you do not refill your prescription timely, the Pharmacy Advisor Program will reach out to you in writing, by telephone, or face-to-face through your CVS pharmacist to remind you to refill your prescription and, in certain cases, provide disease treatment counseling:

- Benign prostatic hypertrophy (BPH)
- Coronary artery disease/ischemic heart disease
- Diabetes
- Heart failure
- High Cholesterol
- Hypertension
- Parkinson’s disease
- Respiratory diseases
- Rheumatoid arthritis
The goal of the Program is to drive favorable behavior changes in the short term and improve clinical outcomes over the longer term by encouraging adherence with your physician’s prescribed drug treatment of your chronic condition.

“Dispense as Written” Rule

MCTWF encourages the use of generic drugs by covering them at much lower patient cost than it does for brand name drugs. A generic drug must have the same active ingredients as its brand name counterpart and are considered by the U.S. Food and Drug Administration identical in dose, strength, route of administration, safety, efficacy, and intended use.

If a generic version of your prescribed brand name drug is available, your MCTWF prescription drug benefit plan only will cover the generic 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 and brand name drug and for payment of the generic copay 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 MCTWF, 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 copay or coinsurance amount.

Glucose Monitoring Supplies Now Also Covered As a Prescription Drug Benefit– Spring 2013

For those who are covered under a MCTWF medical plan, the purchase of glucose monitoring supplies have been covered solely as “Medical Supplies” benefits for lancets and test strips and as “Durable Medical Equipment” benefits for glucose meters (so long as they are prescribed and certified as medically necessary by a licensed physician and obtained from a provider whom Blue Cross Blue Shield has certified as a medical supply or durable medical equipment provider).

Effective February 1, 2013 you also may obtain your prescribed lancets, test strips and glucose meter from any participating in-network pharmacy, at your Plan’s brand copay or coinsurance level. Accu-Chek and One Touch test strips and lancets are the preferred brand products and do not require prior authorization. Freestyle test strips do require prior authorization.

You also 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. To see if you qualify, you can contact CVS Caremark toll-free at 1-800-588-4456.

Brand Drugs Requiring Prior Authorization– Fall 2013

As was first announced in the winter 2011-2012 Messenger, MCTWF’s pharmacy benefit manager, CVS Caremark, made prior authorization of certain brand name prescription drugs a condition of coverage. The following list reflects each drug requiring prior authorization, its therapeutic class, the common medical condition that the class treats, and the alternative drugs in that therapeutic class (i.e., those not requiring prior authorization). Those drugs stated in red print have been newly added by CVS Caremark to the list requiring prior authorization effective January 1, 2014. Please note that generic drugs are in lowercase italics font and brand drugs are in UPPERCASE font. Those who are utilizing any of the listed brand name drugs in red print will be notified, along with their prescribing physician, directly by CVS Caremark and will be provided with a list of covered alternative drugs that are equally or more efficacious.
<table>
<thead>
<tr>
<th>Common Condition/Therapeutic Class</th>
<th>Drug Subject to Prior Authorization</th>
<th>Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are not the direct generic equivalent of the brand drug that is subject to prior authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergies</strong> Nasal Steroids/Combinations</td>
<td>BECONASE AQ</td>
<td>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</td>
</tr>
<tr>
<td>OMNARIS</td>
<td>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX WITH azelastine or ASTEMPRO</td>
<td></td>
</tr>
<tr>
<td>QNASL</td>
<td>VERAMYST</td>
<td>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</td>
</tr>
<tr>
<td>ZETONNA</td>
<td>DYMNISTA</td>
<td>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</td>
</tr>
<tr>
<td><strong>Allergies</strong> Ophthalmic</td>
<td>LASTACAFT</td>
<td>azelastine, cromolyn sodium, ALREX, PATADAY</td>
</tr>
<tr>
<td><strong>Asthma</strong> Beta Agonists, Short-Acting</td>
<td>MAXAIR</td>
<td>PROAIR HFA, PROVENTIL HFA</td>
</tr>
<tr>
<td>VENTOLIN HFA</td>
<td>XOPENEX HFA</td>
<td></td>
</tr>
<tr>
<td><strong>Asthma</strong> Steroid Inhalants</td>
<td>ALVESCO</td>
<td>ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR</td>
</tr>
<tr>
<td><strong>Asthma or Chronic Obstructive Pulmonary Disease (COPD)</strong> Steroid/Beta Agonist Combinations</td>
<td>BREO ELLIPTA</td>
<td>ADVAIR, DULERA, Symbicort</td>
</tr>
<tr>
<td><strong>Chronic Obstructive Pulmonary Disease (COPD)</strong> Anticholinergics</td>
<td>TUDORZA PRESSAIR</td>
<td>SPIRIVA</td>
</tr>
<tr>
<td><strong>Depression</strong> Antidepressants</td>
<td>OLEPTRO</td>
<td>trazodone</td>
</tr>
<tr>
<td><strong>Diabetes</strong> Biguanides</td>
<td>GLUMETZA</td>
<td>metformin, metformin ext-rel</td>
</tr>
<tr>
<td>RIOMET</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong> Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</td>
<td>NESINA</td>
<td>JANUVIA, TRAJENDIA</td>
</tr>
<tr>
<td>ONGLYZA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong> Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations</td>
<td>KAZANO</td>
<td>JANUMET, JANUMET XR, JENTADUETO</td>
</tr>
<tr>
<td>KOMBIGLYZE XR</td>
<td>OSENI</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong> Insulins</td>
<td>HUMALOG</td>
<td>APIDRA, NOVOLOG</td>
</tr>
<tr>
<td>HUMALOG MIX 50/50</td>
<td>NOVOLOG MIX 70/30</td>
<td></td>
</tr>
<tr>
<td>HUMALOG MIX 75/25</td>
<td>NOVOLOG MIX 70/30</td>
<td></td>
</tr>
<tr>
<td>HUMULIN 70/30</td>
<td>NOVOLIN 70/30</td>
<td></td>
</tr>
<tr>
<td>HUMULIN N</td>
<td>NOVOLIN N</td>
<td></td>
</tr>
<tr>
<td>HUMULIN R</td>
<td>NOVOLIN R</td>
<td></td>
</tr>
<tr>
<td>NOTE: Humulin U-500 concentrate will bet be subject to removal and will continue to be covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong> Supplies</td>
<td>BREEZE 2 STRIPS AND KITS</td>
<td>ACU-CHER STRIPS AND KITS, ONE TOUCH STRIPS AND KITS</td>
</tr>
<tr>
<td>CONTOUR STRIPS AND KITS</td>
<td>FREESTYLE STRIPS AND KITS</td>
<td></td>
</tr>
<tr>
<td>CONTOUR NEXT STRIPS AND KITS</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Erectile Dysfunction</strong> Phosphodiesterase Inhibitors</td>
<td>LEVITRA</td>
<td>CIALIS, VIAGRA</td>
</tr>
<tr>
<td><strong>Glaucoma</strong> Prostaglandin Analog</td>
<td>LUMIGAN</td>
<td>latanoprost, TRAVATAN Z, ZIOPTAN</td>
</tr>
<tr>
<td><strong>Growth Hormones</strong></td>
<td>GENOTROPIN</td>
<td>HUMATROPE, NORDITROPIN</td>
</tr>
<tr>
<td>SAIZEN</td>
<td>OMNITROPE</td>
<td></td>
</tr>
<tr>
<td>NUTROPIN/NUTROPIN AQ</td>
<td>TEV-</td>
<td></td>
</tr>
<tr>
<td><strong>High Blood Pressure</strong> Angiotensin II Receptor Antagonists</td>
<td>EDARBI</td>
<td>candesartan, eprosartan, irbesartan, losartan, BENICAR, DIOVAN, MICARDIS</td>
</tr>
<tr>
<td><strong>High Blood Pressure</strong> Angiotensin II Receptor Antagonist/Diuretic Combinations</td>
<td>EDARBYCLOR</td>
<td>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, valsartan-hydrochlorothiazide, BENICAR HCT, MICARDIS HCT</td>
</tr>
<tr>
<td>TEVETEN HCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High Cholesterol</strong> HMG Co-A Reductase Inhibitors (HMGs or Statins)</td>
<td>ALTTOPREV LIVALO</td>
<td>atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, CREOSTR</td>
</tr>
<tr>
<td>LESCOL XL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCTWF 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 about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription

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

2. MCTWF has determined that the prescription drug coverage offered by the above stated Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**Notice of Creditable Coverage – Fall 2013**

The following Notice 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:

**Important Notice from the Michigan Conference of Teamsters Welfare Fund (MCTWF) About Your Prescription Drug Coverage and Medicare**

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

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

2. MCTWF has determined that the prescription drug coverage offered by the above stated Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When can you 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.

**What happens to your current coverage if you decide to join a Medicare Drug Plan?**

If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF 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 preauthorization requirements for non-sedating antihistamines, proton pump inhibitors, selective

**To obtain prior authorization, your physician must contact CVS Caremark at 800-626-3046**

**Common Condition/ Therapeutic Class** | **Drug Subject to Prior Authorization** | **Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are not the direct generic equivalent of the brand drug that is subject to prior authorization)**
--- | --- | ---
High Cholesterol HMG Co-A Reductase Inhibitor Combinations | ADVICOR | atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, SIMCOR
LIPITRUZET | atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, VYTORIN
Inflammatory Bowel Disease (IBD), Ulcerative Colitis Aminosalicylates | ASACOL HD DELZICOL | balsalazide, sulfasalazine, sulfasalazine delayed-rel, APRISO, LIALDA, PENTASA
SUBOXONE FILM | buprenorphine/haloxone sublingual tablets
Overactive Bladder/Incontinence Urinary Antispasmodics | DETROL LA TOVIAZ | oxybutynin ext-rel, tolterodine, trospium, trospium ext-rel, GELNIQUE, VESICARE
Pain and Inflammation Nonsteroidal Anti-inflammatory Drugs (NSAIDs) | FLECTOR | diclofenac, meloxicam, naproxen
Pain and Inflammation Corticosteroids | RAYOS | dexamethasone, methylprednisolone, prednisone
Prostate Condition Benign Prostatic Hyperplasia Agents/Combinations | JALYN | finasteride or AVODART WITH alfuzosin ext-rel, doxazosin, tamsulosin, terazosin or RAPAFLO
Hypnotics, Non-benzodiazepines | INTERMEZZO ROZEREM | zolpidem, zolpidem ext-rel
Testosterone Replacement Androgens | ANDROGEL TESTIM | ANDRODERM, AXIRON, FORTESTA
Immunosuppressants, Calcineurin Inhibitors | Hectoria | tacrolimus

**Messenger Compilation**
November 2013
serotonin reuptake inhibitors, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), oral acne, topical acne (age 26 and above) and oral anti-fungal drugs with both retail and mail order availability, subject to generic and brand copays, 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.

**When will you pay a higher premium (penalty) to join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% 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 beneficiary 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 MCTWF’s Customer Communications Department 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 MCTWF changes. You also may request a copy of this notice at any time.

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

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

- Visit www.medicare.gov
- 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
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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 call them at 1-800-772-1213 (TTY 1-800-325-0778).

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 required to pay a higher premium (a penalty).

September 1, 2013
Michigan Conference of Teamsters Welfare Fund

**Removal of Walgreens from Pharmacy Network, January 1, 2014 – Fall 2013**

This is to inform you that effective January 1, 2014 and until further notice, Walgreens will be excluded from the Caremark retail pharmacy network for all MCTWF participants and beneficiaries.

MCTWF’s Trustees have taken this step in light of Walgreens’ decision to replace UPS with FedEx as its package delivery vendor. As a result, The IBT estimates that as many as 2,000 full-time and part-time Teamsters will be laid off.

While we regret any inconvenience caused to you, the Caremark network has over 60,000 other participating retail pharmacies nationwide, so it is likely that you will find an equally accessible network pharmacy. To determine the network pharmacies in your area, please contact MCTWF’s Customer Communications Department, or access www.caremark.com directly or through MCTWF’s website at www.mctwf.org. If a Walgreens pharmacy has your prescription with remaining refill entitlement, simply ask your new pharmacist to arrange for it to be transferred.

As with any non-network pharmacy, if you continue patronizing Walgreens after December 31, 2013, you risk incurring additional out-of-pocket expense, since you will be reimbursed only up to the discounted amount that MCTWF would have paid a network pharmacy, less the applicable copay.

**RIGHT TO RECOVERY**

**Recovery of Benefit Overpayments— Fall 2013**

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. This is to remind you that MCTWF has the right and obligation to recover such overpayments from any person to whom payments were made, from any person for whom payments were made, from any insurance company or organization to which payments were made, as well as directly from you.
COORDINATION OF BENEFITS

Coordination of Benefits (COB) Rules for Employee, Spouse, and Retiree Coverage– Fall 2013

If you and/or your eligible beneficiaries have coverage under another group health plan as well as under an MCTWF Plan, benefits entitlement will be coordinated between the two plans.

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 actively working employee is primary to the [secondary] plan that is covering the patient as a spouse.

The plan covering the patient as an actively working employee is primary to the [secondary] plan covering the patient as a retiree.

The plan covering the patient as a spouse of an actively working employee is primary to the [secondary] plan covering the patient as a 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA Notice of Privacy Practices– Spring 2013

Effective September 23, 2013, modifications to the HIPAA privacy, security and enforcement regulations went into effect, as reflected in the following amended Notice of Privacy Practices (and which also can be found on the HIPAA Privacy Rule page of MCTWF’s website at www.mctwf.org):

Notice of Privacy Practices for Protected Health Information Your Information. Your Rights. Our Responsibilities.

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 friend
• 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
Michigan Conference of Teamsters Welfare Fund

- 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

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.

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 1.
- 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, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
We will not retaliate against you for filing a complaint

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

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. This does not apply to long term care plans. 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. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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 claim
- 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
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.

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.

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.

This Notice is effective September 23, 2013

Privacy Officer: Cory Buchanan
(313) 964-2400 ext. 260
privacyofficer@mctwf.org