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**Compilation of Messenger Notifications  
Fall 2015 through Winter 2021 - 2022**



The *Messenger* is a publication that is used to notify you of changes to your benefit package. 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 2015 to the Winter 2021 - 2022 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 changes.

*February 2022*

**Compilation of *Messenger*  
Notifications Fall 2015 through  
Winter 2021 – 2022**



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## **INTRODUCTION – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

The most recent revision of the Summary Plan Description (SPD) booklet, dated November 2015, was mailed to all MCTWF Actives Plan and MCTWF Retirees Plan participant households. If the SPD booklet (and/or the subsequently mailed Schedule of Benefits) was not received, the Fund will mail it to you at your request. You also may access the SPD booklet and your Schedule of Benefits on the Fund's website at [www.mctwf.org](http://www.mctwf.org) from the *Summary Plan Description* page. To search the SPD booklet for a specific topic, use your search option and enter a key word or phrase. The SPD is scheduled for an updated printing in the Fall of 2020.

## **MCTWF COVID-19 PANDEMIC RESPONSE**

### **COVID-19 RELATED COMMUNICATIONS DURING 2020 (Winter 2020 – 2021)**

The following notification was mailed to members on April 6, 2020:

#### **MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND'S COVID-19 RESPONSE AS OF 04/06/20**

MCTWF's Trustees and staff send you best wishes in the midst of this healthcare crisis and assure you that we remain fully engaged in meeting our responsibilities to you. 90% of our staff are working fully remotely and the balance of us are dividing our time between work that can be done remotely and that which must be handled on premises. I am gratified by the effort and professionalism exhibited by our staff in transitioning to an almost fully remote, highly functioning operation, almost seamlessly, and almost overnight. We understand well the feelings of anxiety, depression, isolation, frustration, and lack of control that so many are experiencing during this pandemic. We hope to demonstrate to you our sincere desire to lighten your load and be of excellent service to you. In response to the perceived needs of our members and to federal mandates, MCTWF's Trustees, as of this date, have authorized implementation of the following:

#### **Telehealth Benefits**

During this period of self-isolation, limited availability of primary care physician appointments and greater concern about contagion in the doctor's office, it makes a great deal of sense to make greater use of your free MDLIVE telehealth benefit for virtual consultations and treatment. MDLIVE physicians are available around the clock and behavioral health therapists are available by appointment. Use the MDLIVE mobile app or call 800-400-MDLIVE. Also, retroactive to March 11, 2020, MCTWF's telehealth benefit is expanded to eligible providers outside of the MDLIVE network (see Messenger, Winter 2019-2020 issue). This expanded benefit is provided with no member cost-share (i.e., no deductible, copay, or coinsurance charge; there may be balance billing to members using out of network providers) for the duration of the public health emergency declared by the Secretary of Health and Human Services on January 31, 2020. Also available, the BCBSM 24-hour Nurse Line at 1-800-775-2583.

#### **Prescription Drug Benefits**

In the interest of ensuring that you have adequate supplies of your maintenance drugs and of minimizing your needed number of visits to your retail pharmacy during the pandemic, network pharmacies will now, upon request, convert your 30-day fills to up to 90-day fills (update: this program ceased 06/14/20) and, if you use a CVS pharmacy, it will arrange for free home deliveries at your request (update: this program ceased 08/31/20).

#### **Covid-19 Testing and Treatment**

- Effective February 4, 2020, medically necessary COVID-19 lab tests are provided with no member cost-share. Please note that such testing must be conducted in accordance with Centers for Disease Control and Prevention (CDC) guidelines.
- Effective March 18, 2020, medically necessary services to evaluate the need for and to administer the COVID-19 test are provided with no member cost-share.
- Effective March 18, 2020, the treatment of COVID-19 is provided with no member cost-share for the duration of the federal public health emergency declared on January 31, 2020.

### **Weekly Accident & Sickness Benefits**

For those participants whose MCTWF benefit package includes Weekly Accident & Sickness Benefits, these benefits are provided when the participant is unable to work due to a non-occupational illness or injury and the employer meets its contribution and status change notification obligations. Accordingly, any eligible participant diagnosed with COVID-19 meets the requirements for Weekly Accident & Sickness Benefits, to the extent it is provided by the participant's MCTWF benefit package, commencing on the 8th day of the disability.

The participant and treating physician must complete MCTWF's COVID-19 Weekly Accident & Sickness Benefits Claim Form and submit it to MCTWF. Effective March 18, 2020, any eligible participant who is directed by a qualified health care professional or public health agency to self-quarantine in connection with COVID-19 will be deemed eligible for Weekly Accident & Sickness Benefits, commencing on the 8th day of the self-quarantine period and continuing for the balance of the self-quarantine period. The participant and treating physician must complete MCTWF's COVID-19 Weekly Accident & Sickness Benefits Claim Form and submit it to MCTWF. Please note, however, that no disability income benefits will be paid for any week in which the participant receives paid leave or other employer compensation. Please refer to our website at [www.mctwf.org](http://www.mctwf.org) for our COVID-19 Update page for current information concerning related MCTWF benefit and rule changes and links to the Centers for Disease Control and Prevention, the U.S. Department of Labor, and other important sources of information.

The following notification was mailed to members, as applicable:

### **IMPORTANT NOTICE REGARDING COBRA CONTINUATION COVERAGE**

(1) Please take note that pursuant to the federal Joint Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (Federal Register page 26351), group health plans, such as the MCTWF Actives Plan, must disregard the "Outbreak Period" running from March 1, 2020 until sixty (60) days after the announced end of the current National Emergency Concerning the Novel Coronavirus (COVID-19) Outbreak for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following COBRA continuation coverage periods and dates: • The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5); • The date for making COBRA premium payments under ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2) (B)(iii) and (C); and • The date to notify the plan of a qualifying event or determination of disability under ERISA section 606(a) (3) and Internal Revenue Code section 4980B(f)(6)(C).

(2) Please also take note that effective May 31, 2020, MCTWF is implementing an administrative rule change under which COBRA continuation coverage eligibility is not established until timely premium payment is received (previously, coverage was provided during the premium payment grace period but retroactively terminated for untimely payment of the premium). Accordingly, for each new coverage period, eligibility will be suspended until receipt of timely payment. Therefore, effective on May 31st, eligibility will be suspended unless premium payment for the period 5/31/20 - 6/27/20 already has been received. Once timely premium payment is received, eligibility will be retroactively reinstated back to May 31st and any eligible claims incurred during the period paid for will be processed. The same process will be followed for each month thereafter. Since, as noted under item (1) above, timely payment is extended until following the "Outbreak Period," the window for making timely payment may not close until well into the future, but during that period, eligibility will remain suspended unless payment is received. As always, payments received will be credited to the oldest unpaid period. This notice will be included with all COBRA Notices and Invoices until such time as the "Outbreak Period" has ended.

### **EXTENSION OF CERTAIN TIME FRAMES**

Please take note that pursuant to the federal Joint Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (Federal Register page 26351), group health plans, such as the MCTWF Actives Plan and MCTWF Retirees Plan, must disregard the "Outbreak Period" running from March 1, 2020 until sixty (60) days after the announced end of the current National Emergency Concerning the Novel Coronavirus (COVID-19) Outbreak for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following coverage periods and dates:

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- The 60-day period to request special enrollment under ERISA section 701(f) and Code section 9801(f);
- The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
- The date for making COBRA premium payments under ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
- The date to notify the plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
- The date within which individuals may file a benefit claim under the plan's claims procedure pursuant to 29CFR2560.503- 1(h);
- The date within which individuals may file an appeal of an adverse benefit determination under the plan's claims procedure pursuant to 29CFR2560.503- 1(h);
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination pursuant to 29CFR2590.715-2719(d)(2)(ii), and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29CFR2590.715- 2719(d)(2)(ii) and 26CFR54.9815-2719(d)(2)(ii).

### **Important Notice about At-Home COVID Testing ( Winter 2021 – 2022)**

As part of its ongoing efforts to expand access to free testing, the federal government is requiring insurance companies and group health plans to cover the cost of over-the-counter (OTC), at-home rapid diagnostic COVID-19 tests without a prescription at a \$0 member cost share, effective January 15, 2022, through the end of the public health emergency.

The new coverage requirement means that MCTWF members can go to a pharmacy, buy a test, and either get it paid for up front, or get reimbursed for the cost (up to \$12 per test) by submitting a claim, with receipt, to CVS/Caremark.

The two coverage options are available to you and MCTWF eligible dependents to obtain the OTC at-home COVID-19 tests as described below:

#### **Direct Coverage at the Pharmacy**

MCTWF will cover the eligible OTC COVID-19 at-home tests with direct reimbursement to the pharmacy and no up-front cost to eligible members. Present your white MCTWF Networks Card at the pharmacy to obtain coverage through your CVS/Caremark pharmacy benefit. While the network is broad, not all pharmacies will have this option available. Check with your local pharmacy for details regarding which OTC COVID-19 at-home tests are covered through your pharmacy benefit.

#### **Direct Member Reimbursement from CVS/Caremark**

Members who purchase OTC COVID-19 at-home tests can receive reimbursement of up to \$12 per test (the lesser of the cost of the test or \$12) by submitting a claim online through caremark.com, or by filing a paper medical claim located on the "Forms" page at www.mctwf.org. A copy of the receipt showing proof of purchase must be uploaded when submitting an online claim for reimbursement or when submitting a paper claim. Details of how to file a claim for reimbursement are located at www.caremark.com/covid19-otc.

Please note the coverage details for both options:

- At-Home Testing coverage is for home use only and is not for employment purposes.
- Allows for the reimbursement of up to eight at-home rapid diagnostic COVID-19 tests per covered individual per 30-day period. (Note: This is the number of total tests covered. If a member purchases a kit with two tests in it, this counts as two tests against the 8 allowed tests.)
- To be covered, tests must be purchased on or after January 15, 2022.

If you have any questions or need assistance in determining what at-home tests are covered, please contact MCTWF's Member Services Call Center at 800-572-7687.

### **GENERAL EXCLUSIONS AND LIMITATIONS – MCTWF ACTIVES AND RETIREES PLANS**

#### **On-the Job Injury or Illness Benefit Exclusion Revision (Spring 2016)**

Effective May 5, 2016, the Fund's Summary Plan Description booklet, under *General Exclusions and Limitations*, has been revised in part to state: "The following are not covered under the MCTWF Actives Plan and MCTWF Retirees Plan: Accidental injury or illness arising in the course of employment."

**Motor Vehicle Accident-Related Personal Injury Claims (Spring 2017)**

For Michigan Residents – Updated Rule

Plan participants and their eligible dependents who reside in the State of Michigan generally are not eligible for medical, prescription drug, or weekly accident and sickness benefits for motor vehicle accident-related injuries or illnesses. This is due to Michigan's no-fault automobile insurance law, which requires insurers to provide unlimited health care benefits to any person suffering an accidental injury or illness as a result of a motor vehicle accident within the United States, its territories, and possessions or in Canada. Effective May 4, 2017, upon the submission of proof that (1) such payable benefits have been denied (for reasons other than non-payment of policy) and (2) all rights to appeal or otherwise dispute such denial to the auto insurance carrier have been exhausted, the Plan will provide scheduled benefits upon execution of and compliance with the MCTWF Assignment, Subrogation and Reimbursement Agreement.

For Non-Michigan Residents - Clarification

Plan participants and their eligible dependents who reside outside of the State of Michigan are eligible for MCTWF medical, prescription drug, or weekly accident and sickness benefits for motor vehicle accident related injuries or illnesses only to the extent that claims resulting from the accident are in excess of the greater of (1) the required insurance coverage or other financial protection required under applicable state law, or (2) the benefit limits of any other insurance under which the individual is entitled to coverage. Upon the submission of proof that such responsibility has been met, or benefits have been paid or denied (and if denied, that all rights to appeal or otherwise dispute the denial have been exhausted), MCTWF will provide scheduled benefits in excess thereof, upon execution of, and compliance with, the MCTWF Assignment, Subrogation and Reimbursement Agreement. MCTWF will not coordinate with any other plan or insurance carrier in this regard.

**Michigan Auto Insurance Reform Law (Winter 2019 – 2020)**

MCTWF members who reside in the State of Michigan are not eligible for medical or prescription drug benefits for motor vehicle accident-related injuries or illnesses, under the base medical, prescription drug, or weekly accident and sickness benefit components of their MCTWF benefit package. This is due to Michigan's no-fault automobile insurance law, which requires Michigan drivers to carry unlimited medical coverage to pay for their expenses if they are injured in a motor vehicle accident within the United States, its territories, and possessions or in Canada. Upon the submission of proof that (1) such payable benefits have been denied by the auto insurance carrier (for reasons other than non-payment of policy) and (2) all rights to appeal or otherwise dispute such denial to the auto insurance carrier has been exhausted, the Plan will provide scheduled benefits upon execution of and compliance with the MCTWF Assignment, Subrogation and Reimbursement (ASR) Agreement.

Michigan's May 30, 2019, No-Fault Auto Insurance Reform law goes into effect July 2, 2020. Under the Reform law, Michigan drivers will be able to choose lower levels of PIP (personal injury protection) coverage upon renewal of their policies.

Accordingly, MCTWF's rules for auto-related injury or illness benefits for members who reside outside of Michigan will apply to Michigan members as well. Eligibility for such benefits will be available only to the extent that claims resulting from the accident are in excess of the greater of (1) the required insurance coverage or other financial protection required under applicable state law, or (2) the benefit limits of any other insurance under which the individual is entitled to coverage. Upon the submission of proof that such responsibility has been met, or benefits have been paid or denied (and if denied, that all rights to appeal or otherwise dispute the denial have been exhausted), MCTWF will provide scheduled benefits in excess thereof (and only in excess thereof; MCTWF does not coordinate with any other plan or insurance carrier in this regard), upon execution of, and compliance with, the MCTWF Assignment, Subrogation and Reimbursement Agreement.

**MCTWF Participant Web Portal – New Look Coming Soon**

MCTWF has been providing participants and covered dependents (over 18 years of age) around the clock access to personal information via a secured participant portal since 2006.

The New Portal will be accessed through the MCTWF website [www.mctwf.org](http://www.mctwf.org). After the launch, planned for late 2021, you will be automatically redirected to the New Portal where new participant portal members can register and current participant portal members will be asked to create a new account in the New Portal in order to view your personal account information.

## ELIGIBILITY – MCTWF ACTIVES PLAN

### **Adult Dependent Children Up to Age 26 – New Open Enrollment Window (Fall 2015)**

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.

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.

The Trustees have authorized another enrollment period for those adult children, beginning November 1, 2015, and ending December 16, 2015, to permit eligibility for coverage commencing on or after January 1, 2016 (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, 2015, and December 16, 2015. This form is available on the Forms page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org) or by contacting MCTWF's Member Services Call Center. Please note that the Application must be timely submitted 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.

### **Untimely Reporting of Employee Status Changes (Spring 2016)**

The Fund requires that all contributing employers timely report all active employment status changes (i.e., layoffs, terminations, resignations, personal leaves, military leaves, work related and non-work-related illnesses and injuries, and other changes in status) so that the Fund can update its benefit eligibility records. The employer's failure to do so may result erroneously in the provision of ongoing benefits for members who no longer are eligible. If you are no longer eligible, please inform your healthcare providers, including your pharmacist, that you no longer are covered for Fund benefits. Pharmacists, in particular, will assume that you are still covered by the Fund unless you inform them otherwise. The Fund will be obliged to pursue you to recover the cost of benefits erroneously provided to you.

### **Adult Dependent Children Up to Age 26 – New Open Enrollment Window (Fall 2016)**

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.

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.

The Trustees have authorized another enrollment period for those adult children, beginning November 1, 2016, and ending December 31, 2016, to permit eligibility for coverage commencing on or after January 1, 2017 (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 completed and received by MCTWF between November 1, 2016, and December 31, 2016. This form is available on the *Forms* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org), or by contacting MCTWF's Member Services Call Center. Please note that the Application must be timely submitted 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.

### **Dependent Eligibility for Wards of Guardians (Fall 2016)**

Effective September 29, 2016, the MCTWF Actives Plan definition of Dependent has been expanded to include minor children whose legal guardian is either a MCTWF covered participant or his spouse.

### **Survivor Health Benefits – Clarification (Fall 2015)**

MCTWF's Survivor Health Benefits, which was announced in the fall 2014 issue of the *Messenger*, provides up to 36 months (subject to ongoing eligibility rules) of free medical and prescription drug coverage for all eligible spouses and dependent

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children of participants who die while actively covered under a MCTWF benefits package covering such benefits (through active employment, MCTWF strike coverage, MCTWF benefit bank coverage, or weekly accident and sickness benefit coverage). However, if at the time of death the deceased participant's employer has ceased to maintain MCTWF benefits for the deceased participant's employee unit, his survivors will not be eligible for Survivor Health Benefits.

### **Benefit Bank Weeks Renewal (Winter 2017 – 2018)**

We are pleased to announce that the Trustees have renewed MCTWF's standard benefit bank week program for SOA, Key 1, Key 1a, Key 1b, Key 2, Key 2a, Key 2b, Key 2c, Key 2d, Key 3, and Key 3a medical benefit packages for the 36-month period commencing April 1, 2018, as follows:

- Eligible participants who are actively employed on or after April 1, 2018, will be allotted six benefit bank weeks for use during the period April 1, 2018, through March 31, 2021, during periods in which they are not actively employed.

However, no benefit bank week coverage is available in the event that the participant quits his employment.

- Benefit bank week coverage includes the medical benefits, and any prescription drug, dental and vision benefits provided for in the participant's active benefit package. No Weekly Accident and Sickness, Total and Permanent Disability, or Death (or Accidental Death & Dismemberment) benefits will be available when incurred during the period covered by benefit bank weeks.
- Participants who are not actively employed on March 31, 2018, and who are receiving coverage due to their remaining benefit bank week allotment for the 2015 through 2018 period will continue to be covered until their remaining benefit bank weeks are exhausted, or, if earlier, upon their return to active employment. Once contributions are received with regard to their resumption of active employment, they will receive a new allotment of six benefit bank weeks for use through March 31, 2021.

### **Survivor Health Benefits – SPD Clarification (Winter 2017 – 2018)**

The following rewrite of the "Eligibility – Initial and Ongoing" subsection of the "Actives Survivor Health Benefits" section of the MCTWF SPD booklet (Sec. 2.1(m) adds language that was inadvertently omitted from the published SPD booklet:

#### **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:
  - For the surviving spouse, for the earlier of 36 months or –
    - remarriage; or
    - enrollment in the MCTWF Retirees Plan (Note: the spouse may defer enrollment until timely expiration of other 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

If 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.

**Continuation of Coverage Beyond Age 26 for Disabled Dependent (Winter 2017 – 2018)**

A covered dependent is a MCTWF Actives Plan participant's natural or stepchild or a child who has been placed with a participant for adoption, or who has been adopted, and is eligible for MCTWF Actives Plan benefits. Dependent eligibility ceases at the end of the child's 26th birthday month, except if the child is unmarried and, prior to age 26, was determined by a physician, psychologist, or psychiatrist to be totally and permanently disabled. Total and permanent disability means that the person 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 in regard to education, training, or experience.

If the disabled child is age 26 or greater and the total and permanent disability began before the child was covered under the MCTWF Actives Plan, the child's eligibility as a covered dependent is contingent upon documentation evidencing that he was covered as the participant's dependent under the participant's health plan on the day immediately preceding participant's establishment of eligibility under the MCTWF Actives Plan.

To continue coverage, a Request for Continuation of Coverage beyond Age 26 for Totally & Permanently Disabled Dependent form must be fully filled out and sent to MCTWF along with medical records supporting the dependent's total and permanent disability. This form is available on the Forms page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org) or by contacting MCTWF's Member Services Call Center.

**Benefit Bank Weeks Renewal (Winter 2020 – 2021)**

We are pleased to announce that the Trustees have renewed the MCTWF Benefit Bank Week allotment program for another 36 months, to commence following the March 31, 2021 expiration of the current 36-month period, for MCTWF benefit packages that include the SOA, Key 1, Key 1a, Key 1b, Key 2, Key 2a, Key 2b, Key 2c, Key 2d, Key 3, or Key 3a medical benefits as follows:

- Eligible participants who are actively employed on or after April 1, 2021, will be allotted six benefit bank weeks for use during the period April 1, 2021 through March 31, 2024 during periods in which they are not actively employed. However, no benefit bank week coverage is available in the event that the participant quits his employment.
- Benefit bank week coverage includes the medical benefits, and any prescription drug, dental and vision benefits provided for in the participant's active benefit package. No Weekly Accident and Sickness, Total and Permanent Disability, or Death (or Accidental Death & Dismemberment) benefits will be available when incurred during the period covered by benefit bank weeks.
- Participants who are not actively employed on March 31, 2021, and who are receiving coverage due to their remaining benefit bank week allotment for the 2018 through 2021 period will continue to be covered until their remaining benefit bank weeks are exhausted, or, if earlier, upon their return to active employment. Once contributions are received with regard to the participant's resumption of active employment, the participant will receive a new allotment of six benefit bank weeks for use through March 31, 2024.

**Actives Survivor Health Benefits (Winter 2020 – 2021)**

If a participant dies while actively working and covered for medical and prescription drug benefits under the MCTWF Actives Plan, his eligible spouse and dependent children will be provided with up to 36 months of ongoing medical and prescription drug coverage that his group was entitled to at the time of his death, as described in detail in the MCTWF Summary Plan Description booklet. Prior to October 1, 2020, MCTWF's rule was that if the deceased participant's Employer was to withdraw from MCTWF participation, Actives Survivor Health Benefits entitlement by the surviving spouse and dependent children would cease at the same time as the Employer's withdrawal. The Trustees have amended the rule so that for any death that occurs(ed) while actively working on or after July 1, 2019, the Employer's withdrawal from MCTWF participation will not affect the right of the surviving spouse and children to continued Actives Survivor Health Benefits. Those who were affected by this rule change have been notified and their coverage has been retroactively reinstated.

**Keeping Required Enrollment Information Current (Winter 2020 – 2021)**

Certain information concerning participants and their beneficiaries (i.e., their spouse and eligible children) is essential to MCTWF's proper and accurate administration of the Plan. All MCTWF participants must provide it with all required information concerning themselves and their beneficiaries to permit initial enrollment. It is necessary for participants to keep MCTWF informed of any change to their required information, including marriage, divorce, birth of child, child adoption, change of address, change of email address, change of phone number, other insurance information (COB), change in death benefit beneficiary designation, etc. Notification must occur immediately when such change occurs.

**Do You Have Current MCTWF ID Cards? (Fall 2021)**

Some participants might have older versions of the MCTWF ID Cards (both the white and the gold cards) in their possession. Over the years, some of the contact and resource numbers printed on the MCTWF ID Cards have changed. See the pictured sample of the current cards with the current phone numbers so you can tell if your card(s) is outdated. The white cards are not the same for everyone because the card type is based on what types of benefit you have, i.e., medical, prescription, dental, vision or combination of those benefits. It is important to get a new card if you are still in possession of an old MCTWF card.

Call Member Services Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800) 572-7687 to order replacement or lost MCTWF ID Card(s).

**Keeping MCTWF Informed Regarding Family Status is Important \*Fall 2021)**

Certain information concerning participants and their beneficiaries (i.e., spouse and eligible children) is essential to MCTWF's proper and accurate administration of the Plan. All MCTWF participants must provide all required documentation concerning themselves and all of their eligible beneficiaries to permit initial enrollment. It is necessary for participants to keep MCTWF informed of any change to their family status, including marriage, divorce, birth of child, child adoption, change of address, change of email address, change of phone number, or other insurance information (COB), etc. Notification must occur immediately when such changes occur by submitting a *Change in Family Status Form* or a *Contact Update Form*. Both forms are available on the Forms page of the Fund's website.

If you fail to notify the Fund of a family status change and a dependent becomes ineligible for benefits, any benefits paid while ineligible will be considered overpaid and you will be responsible for reimbursing the Fund for those benefits paid. If reimbursement is not made, your coverage for benefits and those of your eligible family members will be suspended until such time as the benefits are repaid.

For any questions, contact Member Services Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800)572-7687.

**COBRA CONTINUATION OF COVERAGE**

**COBRA Continuation Coverage - Contribution Tiers (Spring 2017)**

COBRA continuation coverage contribution rates are based on two coverage tiers, "single" and, for two or more people, "family." To date, once paying the family contribution rate, you remain obligated to continue to do so, even when your coverage is reduced to just one person.

Effective May 4, 2017, if during the period of COBRA continuation coverage, coverage for your family unit is reduced to just one person due to death, eligibility for Medicare, or exhaustion of COBRA eligibility periods, your contribution rate will be reduced to the required amount for single tier coverage.

**Revocation of Waiver of COBRA Continuation Coverage (Winter 2019 – 2020)**

Qualified COBRA Beneficiaries (participant, spouse, and children) have 60 days to elect COBRA continuation coverage from the later of (1) the date MCTWF Actives Plan medical coverage is lost as a result of a COBRA qualifying event, or (2) the date of MCTWF's COBRA election notice is provided to the qualified COBRA beneficiaries.

If a COBRA Beneficiary chooses to waive COBRA continuation coverage, he nonetheless has the right to revoke that waiver and elect coverage, if done within the above described 60 days. However, just as if the COBRA continuation coverage had not first been waived, the effective date of the COBRA continuation coverage commencement is the date immediately following the loss of active coverage. COBRA self-contributions are due starting from that date.

**What Is COBRA? (Fall 2021)**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers, and their families, who lose health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals are required to pay the entire premium for coverage up to 102% of the cost to the plan.

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COBRA generally requires that group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice.

COBRA coverage can end prematurely in the any of following cases:

- Failure to pay premiums on time; or
- Employer ceasing to maintain any group health plan; or
- A qualified beneficiary gaining coverage under another group health plan (i.e., with a new employer); or
- Becoming eligible for Medicare benefits.

### **ARPA Subsidy Provides COBRA Funding April 4 through October 2, 2021 (Fall 2021)**

The American Rescue Plan Act of 2021 (ARPA) provides for a 100% COBRA premium subsidy to assist eligible individuals for the period of April 4, 2021, through October 2, 2021 (the “Subsidy Period”). The subsidy is available to those who become COBRA eligible during the Subsidy Period as well as those currently enrolled and those who are within their COBRA continuation window but who failed to elect or previously dropped coverage.

### **Eligibility for the COBRA Subsidy**

The COBRA subsidy is available to any person who loses (or has already lost) their health coverage due to an involuntary termination of employment (for example, layoff) or reduction in hours. Any such individual will be eligible for the subsidy if any of the following apply:

- The individual becomes eligible for COBRA coverage during the Subsidy Period; or
  - The individual is currently enrolled for COBRA coverage; or
  - The individual became eligible for COBRA coverage prior to April 4, 2021, and the period of COBRA coverage to which the individual would be entitled under federal law (18 months) overlaps with the Subsidy Period — even if the individual did not

elect COBRA when it was initially offered or elected COBRA but discontinued it before April 4, 2021.

### **Amount of the Subsidy**

The ARPA provides for a 100% COBRA premium subsidy. As such, during the Subsidy Period, individuals who are eligible for the COBRA subsidy are not required to pay their COBRA premium.

### **Duration of the Subsidy Period**

The duration of the subsidy period is from April 4, 2021, to October 2, 2021. However, an individual would cease to be eligible for the subsidy earlier than October 2, 2021, if the individual’s maximum period of COBRA coverage under federal law (18 months) ends before October 2, 2021. An individual would also cease to be eligible for the subsidy earlier than October 2, 2021, if the individual becomes eligible for coverage (even if not actually enrolled) under another group health plan or Medicare. **Individuals are required to notify MCTWF if they become eligible for such coverage and will be subject to a federal penalty if they fail to do so.**

### **Notices**

Notices were provided to beneficiaries who potentially qualify for the subsidy. For those members who received a COBRA notice previously but did not elect COBRA when it was initially offered or elected COBRA but allowed it to discontinue before April 4, 2021, a new notice was provided prior to May 31, 2021, as required by ARPA, describing the subsidy with instructions for election.

If you believe you are (or may be, upon a COBRA election) eligible for the subsidy and have not received a notice, please contact MCTWF’s Call Center at (313) 964-2400 or (800) 572-7687. A notice will be sent to you along with a *COBRA Election* form and a *Request for Treatment as an Assistance Eligible Individual* form which must be fully completed. Upon receipt by MCTWF of the required forms, a determination will be made regarding your eligibility for the subsidy.

**ELIGIBILITY – MCTWF RETIREES PLAN**

**Eligibility for MCTWF Retirees Plan – Post CBA Expiration (Fall 2015)**

The rule has been that the right of a retiring employee to enroll in the MCTWF Retirees Plan is suspended upon the expiration of his Collective Bargaining Agreement (CBA) and will remain so unless the parties agree to renew participation in MCTWF.

Effective October 1, 2015, this rule has been amended to permit an otherwise eligible affected retiree to enroll during the above-described period if he is at least age 57 and has at least 30 years of participation in MCTWF.

**MCTWF Retirees Plan Enrollment Expanded Eligibility Rules (Winter 2019 – 2020)**

For participants who at the time of retirement are no longer covered under a qualifying benefit package (i.e., one that includes the Retiree Medical Program component) and therefore are not eligible to enroll in the MCTWF Retirees Plan Medical Program under standard historical service requirements, enrollment in a Retiree Medical Program benefit package will be permitted at self-contribution rates 10% higher than published rates if an active participant who is currently eligible under a MCTWF benefit package that includes a Base Medical component, but does not include the Retiree Medical Program component, meets one of the following expanded eligibility requirements:

- a. retires at age 57 or greater and has participated in an eligible MCTWF benefit package (i.e., one that includes the retiree medical component) for a minimum of seven of the immediately prior 10 years preceding the Retirement Date, or a minimum of 10 of the immediately prior 15 years preceding the Retirement Date. Each year must have at least 40 weeks paid in each 52-week period to be counted as a year of participation. Once the eligibility requirements are met, the participant will not lose his right to enroll solely by delaying his retirement.
- b. retires at age 57 or greater and has participated in an eligible MCTWF benefit package (i.e., one that includes the retiree medical component) for a total of 15 years at any time. Each year must have at least 40 weeks paid in each 52-week period to be counted as a year of participation.

All other Retiree Medical Program requirements apply to participants who qualify based on either expanded eligibility requirement.

**MCTWF Retirees Plan Health Benefit Rates (Spring 2016)**

The standard and expanded monthly self-contribution rates listed below apply to all those participating in the Fund’s basic Retirees Health Benefit Package 145, which have not increased from last year’s rates. For those purchasing Retirees Health Benefit Package 475 (which includes the Retiree Supplemental Benefits Rider - hearing, vision, and Dental Plan 2 benefits), add \$100.75 (a decrease from last year’s rate) to Retirees Health Benefit Package 145 monthly rates:

<b>April 2016 Retiree Health Benefit Package 145 Standard Eligibility Rules Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
<b><i>Years Participating under an MCTWF Actives Plan Benefit Package with Retiree Health Component</i></b>						
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>50 – 54</b>	\$785	\$710	\$645	\$575	\$495	\$435
<b>55 – 59</b>	\$605	\$560	\$520	\$475	\$440	\$405
<b>60 – 64</b>	\$435	\$420	\$405	\$385	\$375	\$365
For eligible retirees, whose active employment ceased prior to January 1, 2002: <u>\$365</u>						

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

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<b>April 2016 Retiree Health Benefit Package 145 Expanded Eligibility Rules Monthly Self-Contribution Rate</b>						
<b>(Covers Both the Retiree and the Eligible Spouse)*</b>						
<b>Years Participating under an MCTWF Actives Plan Benefit Package with Retiree Health Component</b>						
<b>Age at MCTWF Retirement Date</b>	<b>7 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>57 – 59</b>	\$665	\$615	\$570	\$525	\$485	\$445
<b>60 – 64</b>	\$480	\$460	\$445	\$425	\$415	\$400

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

\* Eligibility to participate in a Retiree Health Benefit Package (i.e., 145 or 475) 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 Retiree Health Benefit Package 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 Retiree Health Benefit Package’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 Retiree Health Benefit Package at the retiree’s self-contribution rate, unless or until the later of (a) eight years from the date that the retiree’s health benefit package 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 Retiree Health Benefit Package’s cost based rate as an “Extended Retiree Spouse.”

**Increase in MCTWF Retirees Plan Calendar Year Benefit (Spring 2016)**

The MCTWF Retirees Plan health (medical and prescription drug) benefits calendar annual benefit limit, exclusive of Phase III Specified Organ Transplants, per covered individual, has been increased from \$220,000 to \$250,000, effective April 1, 2016.

**MCTWF Retirees Plan Health Benefit Rates (Spring 2017)**

The standard and expanded monthly self-contribution rates listed below apply to all those participating in MCTWF’s basic Retirees Health Benefit Package **145**. These rates are unchanged from last year’s rates. For those purchasing Retirees Health Benefit Package **475** (which includes the Retiree Supplemental Benefits Rider - hearing, vision, and Dental Plan 2 benefits), **add \$100.75** (also unchanged from last year’s rate) to Retirees Health Benefit Package 145 monthly rates. All currently active Retirees have been notified of these self-contribution rates by separate mail.

<b>April 2017 Retiree Health Benefit Package 145 Standard Eligibility Rules Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
<b>Years Participating under an MCTWF Actives Plan Benefit Package with Retiree Health Component</b>						
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>50 – 54</b>	\$785	\$710	\$645	\$575	\$495	\$435
<b>55 – 59</b>	\$605	\$560	\$520	\$475	\$440	\$405
<b>60 – 64</b>	\$435	\$420	\$405	\$385	\$375	\$365

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<b>April 2017 Retiree Health Benefit Package 145 <u>Expanded Eligibility Rules</u> Monthly Self-Contribution Rate (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b><i>Years Participating under an MCTWF Actives Plan Benefit Package with Retiree Health Component</i></b>					
<b>Age at MCTWF Retirement Date</b>	<b>7 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>57 – 59</b>	\$665	\$615	\$570	\$525	\$485	\$445
<b>60 – 64</b>	\$480	\$460	\$445	\$425	\$415	\$400

To drop the Retiree Supplemental Benefits Rider you must have been covered by it for a minimum of 12 months and you must notify the Fund in writing at least 45 days prior to the end of the last calendar month for which you wish to be covered. For example, to drop coverage as of January 1st, the Fund 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 a Retiree Health Benefit Package (i.e., 145 or 475) 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 Retiree Health Benefit Package 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 Retiree Health Benefit Package’s cost-based rates (which also remain unchanged from last year). If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate in the Retiree Health Benefit Package at the retiree’s self-contribution rate, unless or until the later of (a) eight years from the date that the retiree’s health benefit package 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 Retiree Health Benefit Package’s cost based rate as an “Extended Retiree Spouse.”

**MCTWF Retirees Medical Benefit Package Rates for Plan Year: April 2018 – March 2019 (Spring 2018)**

Effective April 2018, the standard and expanded monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical Benefit Package 145. For those purchasing Benefit Package 475 (which includes the Retiree Supplemental Benefits Rider - Hearing, Vision, and Dental Plan 2 benefits), add \$100.10 to Benefit Package 145 monthly rates.

Please note: To drop the Retiree Supplemental Benefits Rider included in Benefit Package 475, you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing at least 45 days prior to the end of the last calendar month for which you wish to be covered. 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.

<b>April 2018 Retiree Medical Benefit Package 145 <u>Standard Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b><i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i></b>					
<b>Age at MCTWF Retirement Date</b>	<b>5 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>50 – 54</b>	\$705	\$640	\$580	\$520	\$445	\$390
<b>55 – 59</b>	\$545	\$505	\$470	\$430	\$395	\$365
<b>60 – 64</b>	\$390	\$380	\$365	\$345	\$340	\$330
For eligible retirees whose active employment ceased prior to January 1, 2002: <u>\$330</u>						

<b>April 2018 Retiree Medical Benefit Package 145 <u>Expanded Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*</b>						
	<b><i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i></b>					
<b>Age at MCTWF Retirement Date</b>	<b>7 – 9</b>	<b>10 – 14</b>	<b>15 – 19</b>	<b>20 – 24</b>	<b>25 – 29</b>	<b>30 +</b>
<b>57 – 59</b>	\$600	\$555	\$515	\$475	\$435	\$400
<b>60 – 64</b>	\$430	\$420	\$400	\$380	\$375	\$360

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<b>April 2018</b>		
Retiree Medical Benefit Package 145 <b>Extended Retiree Spouse*</b> Monthly Self-Contribution Rates (For Benefit Package 475, add \$100.10)		
Age at Start of Each Plan Year	5 – 9	10 – 14
50 – 52	\$526.70	\$428.80
53 – 55	\$574.70	\$543.20
56 – 58	\$596.50	\$664.75
59 – 61	\$617.65	\$781.60
62 – 64	\$652.75	\$870.00

\* Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) 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 at the retiree self-contribution rate that would have been applicable to the retiree until or unless non-deferred participation (i.e., eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree’s self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, 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 Extended Retiree Spouse rates for the applicable benefit package.

**Retiree Medical Benefit Package Rates for Plan Year April 2020 – March 2021 (Winter 2019 – 2020)**

The standard and expanded monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical Benefit Package 145. For those purchasing Benefit Package 475 (which includes the Retiree Supplemental Benefits Rider — Hearing, Vision, and Dental Plan 2 benefits), add \$104.90 to Benefit Package 145 monthly rates. Please note: To drop the Retiree Supplemental Benefits Rider included in Benefit Package 475, you must have been covered by it for a minimum of 12 months and you must notify MCTWF in writing at least 45 days prior to the end of the last calendar month for which you wish to be covered. For example, to drop coverage as of January 1, MCTWF must receive written notification by November 15. Once the Retiree Supplemental Benefits Rider is dropped, it will not be available to you again.

<b>April 2020</b>						
Retiree Medical Benefit Package 145 <u>Standard Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	<i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i>					
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
<b>50 – 54</b>	\$735	\$665	\$605	\$545	\$465	\$410
<b>55 – 59</b>	\$570	\$530	\$490	\$450	\$415	\$385
<b>60 – 64</b>	\$410	\$400	\$385	\$360	\$355	\$345
For eligible retirees whose active employment ceased prior to January 1, 2002: \$330						
<b>April 2020</b>						
Retiree Medical Benefit Package 145 <u>Expanded Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	<i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i>					
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
<b>57 – 59</b>	\$625	\$585	\$540	\$495	\$455	\$425
<b>60 – 64</b>	\$450	\$440	\$425	\$395	\$390	\$380

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<b>April 2020                      Retiree Medical Benefit Package 145 <u>Extended Retiree Spouse*</u></b> <b>Monthly Self-Contribution Rates</b> <b>(For Benefit Package 475, add \$104.90)</b>		
<b>Age at Start of Each Plan Year</b>	<b>Female</b>	<b>Male</b>
<b>50 – 52</b>	\$563.55	\$458.80
<b>53 – 55</b>	\$614.90	\$581.20
<b>56 – 58</b>	\$638.25	\$711.20
<b>59 – 61</b>	\$660.85	\$836.30
<b>62 – 64</b>	\$698.45	\$930.90

\*Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) ceases for the retiree or the spouse eligible for Medicare Part A coverage or engages in 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 at the retiree self-contribution rate that would have been applicable to the retiree until or unless non- deferred participation (i.e. eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree’s self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, 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 Extended Retiree Spouse rates for the applicable benefit package.

Reminder: In addition to the other causal events stated in your Summary Plan Description, entitlement to MCTWF Retirees Plan benefits ceases as of the earlier of a) the first of the month in which the retiree’s or spouse’s 65th birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage. It is imperative that the individual immediately call to inform MCTWF of his early Medicare eligibility date and that the individual immediately cease the use of MCTWF Retiree benefits.

MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. MCTWF will pursue recovery for any Retiree benefits paid for services incurred on or after the individual’s Medicare eligibility date.

**Retiree Medical Benefit Package Rates for Plan Year April 2021 - March 2022 (Winter 2020 – 2021)**

The standard and expanded eligibility monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical and prescription drug Benefit Package 145. For those purchasing Benefit Package 475 (which adds to the basic medical and prescription drug benefits the Retiree Supplemental Benefits Rider — Hearing, Vision, and Dental Plan 2 benefits), add \$105.30 to Benefit Package 145 monthly rates.

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April 2021 Retiree Medical Benefit Package 145 <u>Standard Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
<i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i>						
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
50 – 54	\$740	\$670	\$610	\$550	\$470	\$415
55 – 59	\$575	\$535	\$495	\$455	\$420	\$390
60 – 64	\$415	\$405	\$390	\$365	\$360	\$350
For eligible retirees whose active employment ceased prior to January 1, 2002: \$350						

April 2021 Retiree Medical Benefit Package 145 <u>Expanded Eligibility</u> Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
<i>Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component</i>						
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
57 – 59	\$635	\$590	\$545	\$500	\$460	\$430
60 – 64	\$455	\$445	\$430	\$400	\$395	\$385

April 2021 Retiree Medical Benefit Package 145 <u>Extended Retiree Spouse*</u> Monthly Self-Contribution Rates (For Benefit Package 475, add \$105.30)		
Age at Start of Each Plan Year	Female	Male
50 – 52	\$580.65	\$472.70
53 – 55	\$633.55	\$598.80
56 – 58	\$657.60	\$732.85
59 – 61	\$680.90	\$861.65
62 – 64	\$719.60	\$959.10

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\*Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) 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 at the retiree self-contribution rate that would have been applicable to the retiree until or unless non-deferred participation (i.e., eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree's self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, 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 Extended Retiree Spouse rates for the applicable benefit package. Reminder: In addition to the other causal events stated in your Summary Plan Description, entitlement to MCTWF Retirees Plan benefits ceases as of the earlier of a) the first of the month in which the retiree's or spouse's 65th birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage. It is imperative that the individual immediately call to inform MCTWF of his early Medicare eligibility date and that the individual immediately cease the use of MCTWF Retiree benefits. MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. MCTWF will pursue recovery for any Retiree benefits paid for services incurred on or after the individual's Medicare eligibility date.

### Retiree Medical Benefit Package Rates for Plan Year April 2022 - March 2023 (Winter 2021 – 2022)

The standard and expanded eligibility monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical and prescription drug Benefit Package 145. For those purchasing Benefit Package 475 (which adds to the basic medical and prescription drug benefits the Retiree Supplemental Benefits Rider – Hearing, Vision, and Dental Plan 2 benefits), add \$99.90 to Benefit Package 145 monthly rates.

April 2022 Retiree Medical Benefit Package 145 Standard Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
50 – 54	\$745	\$675	\$615	\$555	\$475	\$420
55 – 59	\$580	\$540	\$500	\$460	\$425	\$395
60 – 64	\$420	\$410	\$395	\$370	\$365	\$355
For eligible retirees whose active employment ceased prior to January 1, 2002: \$355						

April 2022 Retiree Medical Benefit Package 145 Expanded Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	5 – 9	10 – 14	15 – 19	20 – 24	25 – 29	30 +
57 – 59	\$640	\$595	\$550	\$505	\$470	\$435
60 – 64	\$460	\$450	\$435	\$405	\$400	\$390

April 2022 Retiree Medical Benefit Package 145 Extended Retiree Spouse* Monthly Self-Contribution Rates (For Benefit Package 475, add \$99.50)		
Age at Start of Each Plan Year	Female	Male
50 – 52	\$576.10	\$469.00
53 – 55	\$628.55	\$594.10
56 – 58	\$652.40	\$727.10
59 – 61	\$675.55	\$854.90
62 – 64	\$713.95	\$951.60

\*Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) 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 at the retiree self-contribution rate that would have been applicable to the retiree until or unless non-deferred participation (i.e., eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree's self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, 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 Extended Retiree Spouse rates for the applicable benefit package.

Reminder: In addition to the other causal events stated in your Summary Plan Description, entitlement to MCTWF Retirees Plan benefits ceases as of the earlier of a) the first of the month in which the retiree's or spouse's 65th birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage. It is imperative that the individual immediately call to inform MCTWF of his early Medicare eligibility date and that the individual immediately cease the use of MCTWF Retiree benefits. MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. MCTWF will pursue recovery for any Retiree benefits paid for services incurred on or after the individual's Medicare eligibility date.

### **Getting Ready to Retire? Remember to Notify your MCTWF Team! (Fall 2021)**

In order to determine your eligibility for participation in the Fund's Retiree Medical Program, our Member Services Department requests that you notify us as soon as you decide to retire, or at least six months in advance of your retirement date.

Please be aware that your notification to a Teamster Pension office, Retiree Club or your Local Union office of your potential retirement will not result in, nor be deemed, notification to the MCTWF office. Please advise the Fund by calling Member Services Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800) 572-7687 or by sending written notification to the attention of our Retiree Department. Entitlement to Retiree Medical Program benefits ceases as of the earlier of a) the first of the month in which the individual's (i.e., the retiree's or spouse's) 65th birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage. It is imperative that the individual (retiree or spouse) immediately call to inform MCTWF of his/her early Medicare eligibility date and that the individual immediately cease the use of Retiree Medical Program benefits. MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. The Retiree Spouse's participation will end on the date the Retiree Spouse first becomes eligible for Medicare coverage, whether or not she enrolls in Medicare coverage. MCTWF will pursue recovery from all individuals for any Retiree Medical Program benefits paid for services incurred on or after the individual's Medicare eligibility date.

## **ELIGIBILITY – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

### **Same Sex Marriage Eligibility – Termination of Domestic Partner Eligibility (Fall 2015)**

In light of the Supreme Court's June 25, 2015, ruling, MCTWF now recognizes as an eligible beneficiary a participant's same sex spouse. In order to effectuate coverage, as with all new spouses, participants must identify their spouse through the submission of an updated MCTWF *Enrollment Card* or a *Change in Family Status*, provide a copy of their marriage certificate, and otherwise comply with MCTWF's spouse eligibility rules.

Now that MCTWF recognizes same sex marriages, those partners who were approved for eligibility under MCTWF's Domestic Partner Eligibility rules and presently participate in MCTWF under those rules will lose MCTWF eligibility effective January 1, 2016.

### **Recognition of Common Law Marriage (Winter 2019 – 2020)**

In determining eligibility for the spouse of a MCTWF Actives Plan or MCTWF Retirees Plan participant, MCTWF recognizes common law marriage only if the state that the spouse resides in is a state that legally recognizes common law marriage. MCTWF requires a copy of an appropriately completed affidavit attesting to the validity of the marriage and attesting to compliance with the law of the spouse's state of residence.

## MEDICAL BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

### **Home Cervical Traction Devices – New Benefit (Fall 2015)**

Cervical Traction can be performed safely at home in lieu of receiving such treatment at a physical therapist's office. Effective August 6, 2015, MCTWF covers the purchase of a physician prescribed Home Cervical Traction Device as a Durable Medical Equipment benefit, subject to prior authorization for medical necessity by MCTWF's Utilization Review Department, based on the following criteria –

- For over-the door cervical traction devices -
  - The patient must have a musculoskeletal or neurologic impairment requiring traction equipment; and
  - The appropriate use of a home cervical traction device must have been professionally demonstrated to the patient and the patient tolerated the device.
- For Pneumatic cervical traction devices applying traction force to other than the mandible, and cervical traction equipment not requiring an additional stand or frame -
  - The member must have a musculoskeletal or neurologic impairment requiring traction equipment;
  - The appropriate use of a home cervical traction device must have been demonstrated to the patient and the patient tolerated the device; and
  - Any of the following criteria is met:
    - ✓ The treating physician orders and documents the medical necessity of 20 pounds or more of home cervical traction; or
    - ✓ The member has temporomandibular joint (TMJ) dysfunction and has received treatment for the TMJ condition; or
    - ✓ The member has distortion of the lower jaw or neck anatomy (e.g., radical neck dissection) such that a chinhalter is unable to be utilized.

### **Non-Surgical Spinal Decompression Therapy (Fall 2015)**

Effective with service dates of January 1, 2016, and after, non-surgical spinal decompression therapy no longer is a MCTWF covered benefit.

### **ABA Coverage for Autism Spectrum Disorders – Benefit Limits Removed (Fall 2015)**

Effective with service dates of January 1, 2016, and after, all limits on MCTWF Applied Behavior Analysis (ABA) coverage for autism spectrum disorders are eliminated.

### **Specialty Medical Carve-Out Program (Fall 2015)**

Effective January 1, 2016, MCTWF will implement in limited form CVS/Caremark's Specialty Medical Carve-Out Program (Program). 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 MCTWF medical benefit and covered under the MCTWF pharmacy benefit. The specialty medication will be available to the provider or patient through the CVS/Caremark specialty pharmacy. In addition to benefiting MCTWF with CVS/Caremark's substantial discounts, the "Program" will manage utilization through prior authorization, step therapy, dose/waste claim management, and education.

### **Concilium – Medical Bill Negotiation (Fall 2015)**

In June, all participants and spouses covered by a MCTWF medical benefits package received new MCTWF Networks Cards. While we urge you to use a Blue Cross Blue Shield participating provider whenever possible to avoid your exposure to balance billing for amounts in excess of MCTWF maximum allowable benefits, as we stated in the notice that accompanied the Cards, effective July 1, 2015 all medical claims for services rendered by non-Blue Cross Blue Shield participating providers are referred by MCTWF to Consilium, an expert bill negotiation vendor, with the goal of eliminating patient balance billing by the provider through Consilium's negotiation of a settlement with it. If Consilium 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, the patient's financial responsibility only will be for the payment of his 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 cannot negotiate 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. For the first three months of MCTWF's use of Consilium, MCTWF members have avoided patient balance billing totaling almost \$400,000.

**Developmental Speech Therapy – New Benefit (Fall 2015)**

MCTWF benefits cover unlimited therapy designed to restore and maintain speech function (restorative speech therapy). Effective November 5, 2015, MCTWF benefits include coverage designed to develop and maintain a child's speech function (developmental speech therapy) when the services provided by the child's school district are deemed by the Fund to be inadequate to meet the child's reasonable needs.

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

Approved developmental speech therapy is paid in accordance with the provider's participating status with BCBS PPO and the patient's medical benefit package, subject to the same coinsurance rate as the restorative speech therapy benefit, a maximum of 30 visits each calendar year, and only until the last day of the month in which the child turns 18 years old.

**Dentist and Dental surgeon Services Covered under Medical Services - Clarification (Fall 2015)**

MCTWF medical benefits cover 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. Charges first are applied against available dental benefit limits before being covered under the member's medical benefits.

**Herpes Zoster (Shingles) Vaccine – Expanded Coverage (Spring 2016)**

Herpes Zoster (shingles) is an acute viral infection caused by the reactivation of the varicella-zoster (chickenpox) virus acquired during childhood. Currently, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, advises covering, as a preventive benefit under the Affordable Care Act, only one dose of the shingles vaccine and only at age 60 or older.

This is despite significant evidence that the incidence of shingles sharply rises beginning at age 50, and that the vaccination's effectiveness appears to last only for approximately 5 years. The Fund's Trustees have decided that effective May 5, 2016, for MCTWF Actives Plan participants and beneficiaries, subject to approval of physician prior authorization requests by the Fund's Utilization Review office, coverage of shingles vaccinations is expanded to include individuals between the ages of 50 and 59 who have a history of recurring shingles infections, provided that the vaccination is administered no less than one year following the onset of the most recent shingles episode. Shingles vaccinations for such individuals will be provided as a medical benefit (subject to applicable deductibles and coinsurance charges). The Fund continues to provide, as a preventive benefit, free coverage for the first shingles vaccination administered on or after age sixty. However, coverage is expanded further to include revaccinations for all eligible participants, no more frequently than once every five years, as a medical benefit. The foregoing applies as well to MCTWF Retirees Plan participants and eligible spouses except that coverage in all cases is provided as a medical benefit.

**Coverage for Medically Necessary, Non-Implantable Contact Lenses (Fall 2016)**

Certain eye conditions cannot be addressed adequately through surgical correction or the use of eyeglasses and require, as medically necessary, the use of special, non-implantable contact lenses. Effective September 28, 2016, the following diagnoses are covered as a medical service when submitted with an appropriate vision procedure code:

- Keratoconus
- Aphakia
- Anisometropia
- Aniseikonia
- Dry Eye Syndrome or Bilateral Lacrimal Glands
- Presence of Intraocular Lens
- Cataract Extraction Status

Medically necessary, non-implantable contact lenses are payable as durable medical equipment and the applicable deductible and/or coinsurance will apply in accordance with your benefit package.

**Prior Authorization for Advanced Imaging Requests and In-Lab Sleep Studies (Fall 2016)**

MCTWF has utilized the Blue Cross Blue Shield of Michigan (BCBSM) Clinical Review Management Program (“Program”) administered by American Imaging Management (AIM) for BCBSM participating providers to obtain prior authorization for outpatient non-emergency “advanced imaging” diagnostic services (i.e., CT scans, MRIs, PET scans, nuclear medicine, and echocardiography) and for all in-lab sleep studies. Prior to November 1, 2016, Michigan providers who did not participate in the Blue Cross Blue Shield networks and all providers outside of Michigan were required to seek prior authorization for advanced imaging and in-lab sleep studies from MCTWF’s Utilization Review Department.

Effective with dates of services November 1, 2016, and after, non-Michigan providers who participate in the Blue Cross Blue Shield networks are required to comply with the Program by seeking prior authorization for outpatient non-emergency advanced imaging diagnostic services from AIM at 800-728-8008. All providers who do not participate in the Blue Cross

BlueShield networks must continue to seek prior authorization for outpatient non-emergency advanced imaging diagnostic services from MCTWF’s Utilization Review Department and all providers outside of Michigan must continue to seek prior authorization for in-lab sleep studies from MCTWF’s Utilization Review Department. Please be aware that if prior authorization is not granted, you will be responsible for the cost of the service.

Those affected by this change will receive new, gold colored BCBSM ID cards with the advanced imaging diagnostic services and in-lab sleep studies phone numbers included on the back. Please begin presenting this card immediately for all medical services and destroy your current BCBSM ID card (but retain your white colored MCTWF Networks card; that card remains ineffect).

**Coverage for Medically Necessary Transgender Services (Fall 2016)**

Effective with dates of services 09/01/16 and after, the Fund has adopted Blue Cross Blue Shield of Michigan’s medical policy guidelines for medically necessary transgender services to provide gender reassignment surgery, hormone therapy, doctor’s office and lab testing, and counseling for participants and beneficiaries with gender dysphoria. Investigational transgender services continue not to be covered.

The established treatments of gender dysphoria include:

- Puberty suppression in adolescents
- Cross-sexual hormone therapy (for masculinization/feminization)
- Medically necessary gender reassignment surgery, which requires prior authorization:
  - Genitalia reconstruction
  - Mastectomy in female-to-male transitions

Gender specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female-to–male transitioned persons who have not undergone amastectomy.
- Prostate cancer screening may be medically necessary for male-to-female transitioned persons who have retained their prostate.
- Cervical screening may be medically necessary for female-to-male transitioned persons, as

needed. Puberty Suppression

Puberty suppression hormones for adolescents (note: these are covered under the participant’s pharmacy benefit) may be indicated for participants and beneficiaries that meet all of the following inclusionary criteria:

- Onset of puberty to at least Tanner stage 2;
- The adolescent dependent child has demonstrated a long-lasting and intense pattern of gender nonconformity of gender dysphoria (whether suppressed or expressed);
- Gender dysphoria emerged or worsened with the onset of puberty;

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- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent dependent child's situation and functioning are stable enough to start treatment;
- The adolescent dependent child has given informed consent and, particularly when the adolescent dependent child has not reached the age of medical consent, the participant and/or spouse or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent dependent child throughout the treatment process; and the absence of contraindications to therapy in the judgment of the managing physician.

### Hormone Therapy

Hormone therapy (note: covered under the participant's pharmacy benefit) may be indicated for participants and beneficiaries that meet all of the following inclusionary criteria:

- Persistent, well-documented gender dysphoria;
- Capacity to make a fully informed decision and to consent for treatments;
- 18 years of age or older (age of majority);
- If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
- The absence of contraindications to therapy in the judgment of the managing physician.

### Gender Reassignment Surgery

Gender reassignment surgery may be indicated for participants and beneficiaries that meet **all** of the following inclusionary criteria:

- Persistent, well-documented gender dysphoria;
- The provider must supply documentation that supports the participant or beneficiary meets criteria for gender assignment surgery;
  - This includes a detailed psychological assessment by either a psychiatrist, PhD prepared clinical psychologist or a master's prepared social worker (MSW) under the supervision of a psychiatrist or PhD prepared clinical psychologist
- 18 years of age or older;
- Capacity to make a fully informed decision and to consent to treatment;
- If significant medical or mental health concerns are present, they must be controlled; and
- 12 continuous months of hormone therapy\* as appropriate to the patient's gender role (unless there is a contraindication to hormonal therapy).
  - The aim of hormone therapy prior to a gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

Some patients receiving transgender services may require and benefit from ongoing behavioral health services, including psychotherapy.

### Exclusions

The following services are excluded under the medically necessary transgender benefit:

- Reversal of transgender surgical procedures.
- All surgical procedures that are primarily cosmetic and not medically necessary including but not limited to:

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- Abdominoplasty
- Blepharoplasty
- Breast enhancements
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Chondrolaryngoplasty (Adam's apple)
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or reduction)
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Forehead lift
- Hair removal
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Speech-language therapy
- Non-covered services

\*Hormonal therapy is not required prior to mastectomy in female-to-male patients.

### **2017 Recommended Child, Adolescent and Adult Immunization Schedules (Spring 2017)**

Immunizations received in accordance with MCTWF's approved schedules below are covered, as noted, under MCTWF Actives Plan and MCTWF Retirees Plan medical benefits, as appropriate, if received from a network provider (please refer to your schedule of benefits for specifics). These schedules follow the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. By going to the below online links you will find valuable additional information, including the footnotes referenced in these schedules.

### **Recommended Adult Immunization Schedule for Adults Aged 19 Years or Older, by Vaccine and Age Group – United States (Spring 2017)**

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Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B <sup>1</sup> (HepB)	1 <sup>st</sup> dose	2 <sup>nd</sup> dose								3 <sup>rd</sup> dose							
Rotavirus <sup>2</sup> (RV) RV1 (2-dose series); RVS (3-dose series)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis <sup>3</sup> (DTaP; <7 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose				4 <sup>th</sup> dose			5 <sup>th</sup> dose					
Haemophilus influenzae type b <sup>4</sup> (Hib)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See footnote 4				3 <sup>rd</sup> or 4 <sup>th</sup> dose, See footnote 4								
Pneumococcal conjugate <sup>5</sup> (PCV13)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose				4 <sup>th</sup> dose								
Inactivated poliovirus <sup>6</sup> (IPV; <18 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose					3 <sup>rd</sup> dose			4 <sup>th</sup> dose					
Influenza <sup>7</sup> (IV)					Annual vaccination (IV) 1 or 2 doses							Annual vaccination (IV) 1 dose only					
Measles, mumps, rubella <sup>8</sup> (MMR)					See footnote 8		1 <sup>st</sup> dose					2 <sup>nd</sup> dose					
Varicella <sup>9</sup> (VAR)							1 <sup>st</sup> dose					2 <sup>nd</sup> dose					
Hepatitis A <sup>10</sup> (HepA)							2-dose series, See footnote 10										
Meningococcal <sup>11</sup> (Hib-MenCY ≥6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)			See footnote 11										1 <sup>st</sup> dose		2 <sup>nd</sup> dose		
Tetanus, diphtheria, & acellular pertussis <sup>12</sup> (Tdap; ≥7 yrs)													Tdap				
Human papillomavirus <sup>13</sup> (HPV)													See footnote 13				
Meningococcal B <sup>14</sup>														See footnote 11			
Pneumococcal polysaccharide <sup>5</sup> (PPSV23)												See footnote 5					

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 for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
  No recommendation

Please refer online to <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2017

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B <sup>1</sup> (HepB)	1 <sup>st</sup> dose	2 <sup>nd</sup> dose			3 <sup>rd</sup> dose												
Rotavirus <sup>2</sup> (RV) RV1 (2-dose series); RV5 (3-dose series)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis <sup>2</sup> (DTaP; <7 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose				4 <sup>th</sup> dose			5 <sup>th</sup> dose					
Haemophilus influenzae type b <sup>4</sup> (Hib)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See footnote 4		3 <sup>rd</sup> or 4 <sup>th</sup> dose, See footnote 4										
Pneumococcal conjugate <sup>2</sup> (PCV13)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose		4 <sup>th</sup> dose										
Inactivated poliovirus <sup>4</sup> (IPV; <18 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose							4 <sup>th</sup> dose					
Influenza <sup>2</sup> (IIV)					Annual vaccination (IIV) 1 or 2 doses							Annual vaccination (IIV) 1 dose only					
Measles, mumps, rubella <sup>2</sup> (MMR)					See footnote 8		1 <sup>st</sup> dose					2 <sup>nd</sup> dose					
Varicella <sup>2</sup> (VAR)							1 <sup>st</sup> dose					2 <sup>nd</sup> dose					
Hepatitis A <sup>2,3</sup> (HepA)							2-dose series, See footnote 10										
Meningococcal <sup>12</sup> (Hib-MenCY ≥6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)				See footnote 11										1 <sup>st</sup> dose		2 <sup>nd</sup> dose	
Tetanus, diphtheria, & acellular pertussis <sup>22</sup> (Tdap; ≥7 yrs)													Tdap				
Human papillomavirus <sup>12</sup> (HPV)													See footnote 13				
Meningococcal B <sup>12</sup>														See footnote 11			
Pneumococcal polysaccharide <sup>2</sup> (PPSV23)												See footnote 5					

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 for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
  No recommendation

Please refer online to <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>

**FluMist® Not Covered this Flu Season (Fall 2016)**

The American Academy of Pediatrics and the Centers for Disease Control and Prevention warn that FluMist® (a live attenuated influenza vaccine administered by intranasal spray) generally has proven ineffective in protecting against influenza strains that were most prominent during the past three flu seasons, especially in children (for whom the nasal spray vaccine was developed), and recommend that children ages 6 months and older receive a seasonal flu shot as the best available protection against influenza. Accordingly, and consistent with Blue Cross Blue Shield of Michigan medical policy, MCTWF will not cover FluMist® nasal spray vaccine for the 2016-2017 flu season.

**Colonoscopy Screenings (Spring 2017)**

MCTWF’s preventive/wellness benefits include no-cost coverage of colonoscopy screenings if the patient’s history reveals no risk factors for colorectal cancer other than being age 50 or greater, or if African American, age 45 or greater. If the screening results are normal and of reasonable quality, a preventive/wellness follow-up colonoscopy is covered once every five years thereafter.

If a preventive/wellness colonoscopy screening fails due to improper or incomplete preparation by the patient, the failed screening will be covered at no cost to the patient, but **effective May 4, 2017**, the follow-up screening will be treated as a medical benefit subject to the cost sharing requirements of the patient’s MCTWF benefit package.

**MDLIVE Telehealth Services – Extension of \$0 Copay Through March 31, 2018 (Spring 2017)**

Three years ago, MCTWF introduced a convenient service for treatment of many non-acute medical conditions through the use of telehealth consultations provided by MDLIVE. MDLIVE provides on-demand access to U.S. Board certified physician and licensed behavioral health therapist consultations. Medical consultations are available 24 hours, 7 days a week, by phone or secure video. Behavioral health consultations are available 8 am to 11 pm Eastern time, Monday through Friday, by secure video only. Members who have used MDLIVE services and have agreed to be surveyed consistently have acknowledged its convenience and ease and their satisfaction with the consultation. MCTWF’s Trustees have extended the \$0 copay policy for another year, through March 31, 2018.

**Register with MDLIVE for a Chance to Win a Prize! (Spring 2017)**

MDLIVE once again will be conducting a drawing to choose two members, each of whom will win a \$100 dollar VISA gift card and an MDLIVE sport water bottle. To be eligible to win, a member must be a MCTWF participant, spouse, or adult child, covered for medical benefits at the time of the drawing, and must have registered with MDLIVE between June 19, 2017, and July 31, 2017. If previously registered, the member must request to be part of the drawing.

Registration is easy and it will speed up the time it will take to arrange for your first consultation when you need it. You can register on-line at [www.mdlive.com/mctwf](http://www.mdlive.com/mctwf), or via the Info Links page of the MCTWF's website, or by phone, with the help of an MDLIVE health services specialist at 888-632-2738. If you previously registered, you will need to send an email by July 31, 2017, to [promotions@mdlive.com](mailto:promotions@mdlive.com) and include on the subject line - "MCTWF Promotion Certification." In the body, state your full name and that you would like to participate in the MDLIVE/MCTWF drawing. Good luck!

**Reconstructive Surgery to Remove Excess Skin (Spring 2017)**

Surgical procedures, treatment, or hospitalization primarily for reconstructive purposes generally are deemed covered services if the procedure is primarily intended to improve/restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process, or if the procedure is intended to correct congenital or developmental anomalies that have resulted in significant functional impairment. Such covered services include the removal of excess skin when deemed by MCTWF to be medically necessary, resulting from massive weight loss, except when due to bariatric surgery.

Effective with dates of service February 2, 2017 and after, subject to prior authorization, MCTWF benefits have been expanded to cover the removal of excess skin in the case of massive weight loss due to bariatric surgery causing functional impairment, including but not limited to, severe rashes or intertrigo (skin inflammation usually in warm, moist areas between skin folds) skin ulceration, pain, etc., that has not responded to conventional medical therapy (e.g., topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics).

**Medical Bill Negotiation (Spring 2017)**

Since July 1, 2015, all unpaid medical claims for services rendered by non-Blue Cross Blue Shield providers have been referred by MCTWF to Consilium, an expert medical bill negotiation vendor, with the goal of settling the bill at MCTWF's expense to protect the patient from provider balance billing (i.e., the difference between the amount billed and MCTWF's maximum allowable benefit). If successful, the patient's financial responsibility is limited to the payment of any required deductible and coinsurance charge. Through March 31, 2017, patients have avoided about \$2 million in balance billing because of this program.

However, effective with August 1, 2017, dates of services, non-Blue Cross Blue Shield lab service providers, ordered by your healthcare provider (other than when you are in a hospital inpatient setting) will not be negotiated by Consilium. It is the patient's responsibility to make sure that lab services used by the physician are being rendered by a Blue Cross Blue Shield participating provider. The non-Blue Cross Blue Shield provider lab claim will be reimbursed to the participant based on MCTWF's maximum allowable benefit amount and subject to out-of-network cost sharing benefit levels.

Please remember always to obtain medical services from a Blue Cross Blue Shield provider, but if you cannot do so, keep in mind that Consilium cannot negotiate a bill that you have already paid. We urge you to resist the non-Blue Cross Blue Shield provider's demand for full payment when services are provided. Assert that your benefit plan provides coverage for out-of-network services and so the provider 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.

**Women's Health and Cancer Rights Act of 1998 (Winter 2017-2018)**

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 (ERISA) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Under the Women's Health Act, group health plans offering mastectomy coverage (such as MCTWF) must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

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### **Medical Coverage for Dental Services (Winter 2017-2018)**

MCTWF provides medical coverage (at out-of-network benefit levels) for dental services rendered to repair accidental injuries (other than those that are work-related or auto-related injuries) to natural teeth, as well as coverage for the correction of congenital and genetic dental abnormalities.

Effective 5/4/17, coverage has been expanded to include the repair of natural teeth when catastrophic compromise of natural teeth occurs as the result of disease, or treatment of a disease.

Payment of allowed charges first will be applied against available dental limits before being covered as a medical benefit.

### **MCTWF Requests for Medical Records (Winter 2017 - 2018)**

On occasion, MCTWF requires the review of medical records to determine your benefit entitlement. All requests for medical records are directed to the patient and a copy of the request is sent to the patient's service provider. Please be aware, however, that if the service provider requires a fee to produce your medical records, MCTWF is not responsible for reimbursing you or paying the provider directly. Medical records include, but are not limited to, hospital records, emergency room reports, ambulance run reports, and office notes from your physician or other medical professional.

### **Coverage for Ambulance Services Who No Transport Occurs (Winter 2017 - 2018)**

For those who are covered under a medical benefits package, eligible expenses are payable for licensed ground, air, or water ambulance services for basic and advanced life support for treatment of a medical emergency. Eligible expenses include transportation to a medical facility, or other treatment location, when transport by any other means would endanger the patient's health, or when the injury requires immediate first aid to stabilize the patient before transport.

Ambulance services are payable without transport in the following situations:

- The ambulance arrives at the scene, the patient is stabilized, and transport either is not needed or is refused.
- The ambulance arrives at the scene but the patient has expired.

### **Digital Breast Tomosynthesis (3D Mammography) Coverage (Winter 2017 - 2018)**

Effective December 7, 2017, MCTWF's annual mammography under the preventative/wellness screening service, where the applicable deductible and/or coinsurance is waived, has been expanded to include the 3D mammography screening service and can be covered in lieu of the standard annual mammography, based on the physician orders, and provided that the service is billed as a screening, subject to your benefit package applicable deductible and/or coinsurance amounts. Otherwise, the service will be covered under the medical benefit and the applicable deductible and/or coinsurance will apply.

### **Private Duty Nursing (Winter 2017 – 2018)**

MCTWF pays for private duty nursing in the patient's home by a registered nurse or licensed practical nurse, for so long as the service is medically necessary and has received prior authorization by MCTWF, subject to renewal authorizations every 30 days after the initial approval.

Private duty nursing is provided to individuals who need skilled care and whose condition requires individual and continuous 24-hour nursing care that is more intense than what is available under MCTWF's home health care benefit.

The purpose of private duty nursing is to assist the patient with medical care and to train caregivers to provide such medical care in the nurse's absence, enabling the patient to remain in his home.

Effective December 7, 2017, the lifetime maximums for private duty nursing have been removed. Private duty nursing that is deemed medically necessary is covered for up to 16 hours of care per day for the transition period from inpatient hospital to home care. Following the transition period, up to 10 hours of care per day will be covered for as long as medical necessity continues.

### **Maternity Benefit – Ultrasound Limit (Winter 2017 – 2018)**

MCTWF's maternity benefits cover pre-natal care, post-natal care, and obstetrical services. Benefits for pre-natal care include up to three ultrasound imaging services per pregnancy. Coverage of any additional ultrasound claims is contingent upon a determination by MCTWF of medical necessity.

**Telehealth Benefit Expansion (Winter 2019 – 2020)**

Approved effective with dates of service April 1, 2020 and after (note: revised to begin retroactively to March 11, 2020 due to the onset of the COVID-19 Pandemic) MCTWF medical benefits have been expanded by MCTWF's Trustees to include telehealth encounters with eligible providers outside of the MDLIVE network, including MDs, DOs, certified nurses, midwives, clinical nurse practitioners, clinical psychologists, clinical social workers, and physician assistants who are authorized to practice in the state in which the patient is located at the time of service and whose telehealth service is within the scope of their practice. For these telehealth encounters not obtained through MDLIVE, the patient will be responsible for the appropriate cost-share (i.e., deductible, copay, or coinsurance payment) and possible balance billing from non-Blue Cross Blue Shield providers, as is the case with all MCTWF covered medical services. Covered telehealth services (please note that Blue Cross Blue Shield providers refer to them as "telemedicine" services) do not include the following: telemonitoring, text, fax, or email communications, medication refill requests, reporting test results, provision of educational materials, scheduling of appointments, registration or updating billing information, reminders for healthcare related issues, referrals to other providers, telemedicine encounters resulting in a face-to-face visit on the same day for the same condition, and telemedicine visits during a post-operative period.

**MDLIVE Telehealth Services – Extension of \$0 Copay Through March 31, 2021 (Winter 2019 – 2020)**

Five years ago, MCTWF introduced a convenient service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE®. This telehealth service provides on-demand access to U.S. Board-certified physicians 24 hours per day, seven days a week, by phone, secure video, or through MDLIVE's mobile app for smartphones and tablets. Patients can discuss their symptoms with a doctor and prescriptions are sent immediately to the pharmacy of choice. At home or on the road, treatment can begin right away. Behavioral health consultations are available by appointment only and secure video is considered the best mode for this type of consultation. Good news! MCTWF's Trustees are extending the \$0 copay policy for another year, through March 31, 2021. Download the MDLIVE mobile app now from the App Store, get it on Google Play or link to it at our website at [www.mctwf.org](http://www.mctwf.org), under the Info Links tab. For more information, call 800-400-MDLIVE.

**Immunization Schedules (Winter 2019 – 2020)**

Immunizations received in accordance with MCTWF's approved schedules are covered under MCTWF Actives Plan and MCTWF Retirees Plan medical benefits. These approved schedules, which can be viewed on-line at [cdc.gov/vaccines/schedules](http://cdc.gov/vaccines/schedules), follow the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

**Influenza Vaccine FluMist® Coverage (Winter 2019 – 2020)**

The Centers for Disease Control and Prevention and the American Academy of Pediatrics advise that FluMist® (an influenza vaccine administered by intranasal spray) has proven effective in protecting against influenza strains for individuals ages two to 49 years old, although a seasonal flu shot for individuals over six months of age remains the best protection. Accordingly, coverage for the FluMist nasal spray vaccine for the 2019-2020 flu season continues to be covered under MCTWF's medical benefits.

Flu and the common cold are both respiratory illnesses, but they are caused by different viruses. Because these two types of illnesses have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, flu symptoms are more intense than the common cold. Colds generally do not result in serious health problems such as pneumonia, bacterial infections, or hospitalizations, but the flu often does.

The best way to prevent seasonal flu is to get vaccinated every year. Once vaccinated, wash hands often to help protect from germs. If soap and water are not available, use an alcohol-based hand rub.

**HPV Vaccine Now Covered to Age 45 (Winter 2019 – 2020)**

The Human Papillomavirus (HPV) vaccine helps prevent infection by the virus responsible for most cervical cancers and genital herpes. The HPV vaccine is now approved by the Food and Drug Administration for men and women from 26 to 45 years old. Previously, the vaccine was only approved for those people up to age 26. Coverage is provided by MCTWF subject to the cost-sharing requirements of the member's MCTWF medical benefit package.

**Shingles Vaccine Coverage (Winter 2019-2020)**

Herpes zoster (shingles) is an acute viral infection caused by the reactivation of the varicella-zoster (chickenpox) virus acquired during childhood. In accordance with Affordable Care Act guidance, the MCTWF Actives Plan follows the recommendation of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices to provide free coverage for shingles vaccinations as a preventive benefit when administered by a Blue Cross Blue Shield PPO participating provider.

Coverage under the MCTWF Actives Plan for the shingles vaccine has changed to reflect the CDC's updated shingles vaccine guidelines due to the availability of a new vaccine, Shingrix®, proven to provide a 97.25% reduction of shingles in vaccinated patients, much higher than the use of the alternative vaccine, Zostavax®. The guidelines recommend:

- Administration of two doses of recombinant zoster vaccine (Shingrix) 2 to 6 months apart to adults age 50 years or older regardless of past episode of herpes zoster or receipt of zoster vaccine live (Zostavax).
- Administration of two doses of Shingrix 2 to 6 months apart to adults who previously received Zostavax at least two months earlier.
- For adults age 60 or older, administration of either Shingrix or Zostavax, although Shingrix is preferred by the CDC.
- Zostavax should not be administered to pregnant women or adults with severe immunodeficiency.

Coverage under the MCTWF Retirees Plan also follows CDC guidelines in this regard, but coverage in all cases is provided as a medical benefit, rather than as a preventive benefit, and therefore subject to cost sharing as prescribed by your Schedule of Benefits.

**Coverage for Intra-Articular Cartilage Injections (Winter 2019 – 2020)**

For those who are covered under a MCTWF medical benefits package and age 40 and older, limited coverage is available for intra-articular cartilage injections to members 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 not obtained sufficient pain relief from conservative non-pharmacological therapy (such as physical therapy) and from simple analgesics and who have failed conservative therapy with a non-steroidal 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.

**Extended Disability Medical Benefits Eligibility (Winter 2019 – 2020)**

The Fund provides Extended Disability Medical Benefits for members who are totally disabled while covered under a MCTWF Actives Plan medical benefits package. Extended Disability Medical Benefits cover only medical services rendered solely in connection with the disabling disability.

To qualify for the Extended Disability Medical Benefit, the treatment or services received after active coverage ceases is limited to a period not to exceed 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 patient is no longer disabled.

ALL of the following conditions must be met:

- the member was totally disabled, as determined by MCTWF's Trustees, when coverage ended and remain continuously disabled until the date the medical expense is incurred; and
- documentation is provided by the physician validating the disability; the documentation must be filed with MCTWF within fifteen months from the date the active coverage ceases; and
- the treatment or services must result from the same injury or illness that existed on the date the coverage ended and caused the total disability; and
- the medical services and prescription drug benefits are covered by and limited to the last benefits package under which the member was covered while active.

For the first 90 days of the Extended Disability Medical Benefits coverage period, the level of benefits provided depends on whether the service provider is in-network. For the last 21 months, coverage is limited to out-of-network levels of coverage regardless of whether or not the patient uses a BCBS PPO network provider. The Affordable Care Act (ACA) maximum out-of-pocket expense is limited to cost-share for claims incurred with BCBS PPO Network providers only.

**Livongo® for Diabetes Management Program (Winter 2019 – 2020)**

MCTWF has partnered with Blue Cross Blue Shield of Michigan and Livongo® to provide a new diabetes management program beginning in March 2020. MCTWF is offering the Livongo for Diabetes Program, through a series of flyers to be mailed shortly by Livongo, to MCTWF members over age 13 who are diabetic with diabetes-related claim history and medical coverage through the MCTWF Actives Plan or MCTWF Retirees Plan. Medical records will be provided by Blue Cross Blue Shield of Michigan for this sole and express purpose. All protected health information is kept strictly confidential and maintained in accordance with HIPAA privacy and security requirements.

All Program enrollees receive a free glucometer which, through Bluetooth technology, automatically sends blood glucose readings to a protected online record. The Program also includes:

- Unlimited free strips and lancets shipped directly to the enrollee's door. Enrollees can order refills of strips and lancets right from the Livongo glucometer.
- Better diabetes monitoring: Livongo's advanced glucometer uploads blood glucose readings to a private account. The meter also provides personalized tips after each reading to support diabetes management.
- Expert support available 24/7: Certified Diabetes Educators are available if needed. They can discuss anything from nutrition to lifestyle changes and will reach out to individuals when a blood glucose reading is out of range, to help when it's needed most.

Enroll by visiting the site at [join.livongo.com/MCTWF](http://join.livongo.com/MCTWF) or find the link at [www.mctwf.org](http://www.mctwf.org) under the Info Links tab.

**Omada® Diabetes Prevention Program (Winter 2019 – 2020)**

MCTWF has partnered with Blue Cross Blue Shield of Michigan and Omada® to provide a digital diabetes prevention program beginning in March 2020. The Omada Program reduces the risk of type 2 diabetes and heart disease by helping prediabetics make the changes that matter most — whether that involves eating less, more activity, more sleep or less stress.

Prediabetes can strike anyone — young or old, big, or small. But in general, there are some clear risk factors that will make you more likely to develop the condition.

Omada combines the latest technology with the tools and ongoing support needed to reach important health goals, one small step at a time. The Omada Diabetes Prevention Program includes:

- A professional health coach for one-on-one guidance.
- A wireless scale to monitor progress.
- Weekly online lessons to educate and inspire.
- A small peer group for real-time support if the enrollee wishes to participate in the group.

Omada's human-centered design, empathetic health coaches, and smart technology work together to ensure that Program enrollees stay committed over time.

During March, all members age 18 and older with MCTWF medical benefits will be mailed Program information and invited to submit an on-line application that will be reviewed by Omada pursuant to Centers for Disease Control and Prevention guidelines. Those members who are determined to be at high risk for being prediabetic and are deemed eligible to enroll in the Program will be invited to do so. Members also may proceed immediately to [omadahealth.com/MCTWF](http://omadahealth.com/MCTWF) or find the link at [www.mctwf.org](http://www.mctwf.org) under the Info Links tab to apply.

**Blue Cross Blue Shield Global Core® Program (Winter 2019 – 2020)**

The Blue Cross Blue Shield Global Core® program (formerly known as BlueCard Worldwide®) gives our members access to medical care outside the United States. For non-emergency inpatient medical care, call the Service Center for Blue Cross Blue Shield Global Core at 1-800-810-2583, or collect at 1-804-673-1177, 24 hours a day, seven days a week.

By making arrangements through the service center, medical services (inpatient or outpatient and doctor care) will be covered at in-network benefit levels. If emergency medical care is needed, or services were not arranged through the Service Center, you may seek reimbursement by completing a Blue Cross Blue Shield Global Core International Claim Form, available on the Forms page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org), or by contacting MCTWF's Member Services Call Center at 800-572-7687. The form should be sent to the address listed at the top of the form. Reimbursement will be subject to the cost-share provisions of your MCTWF benefit package Schedule of Benefits.

### **In-Lab Sleep Studies Require Prior Authorization (Winter 2019 – 2020)**

MCTWF Actives Plan and MCTWF Retirees Plan members can rest assured that all MCTWF medical benefit packages cover sleep studies for members with any of 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.

In light of the significantly higher cost of in-lab rather than home sleep studies, and consistent with Blue Cross Blue Shield of Michigan medical policy, MCTWF requires that all Michigan providers obtain prior authorization for in-lab sleep studies for MCTWF members by contacting AIM Specialty Health at (800) 728-8008. All non-Michigan providers must obtain prior authorization for in-lab sleep studies by contacting MCTWF's Utilization Review Department at (800) 572-7687, extension

428. To obtain prior authorization, the provider must justify why an in-lab sleep study is more clinically appropriate for the patient than a home sleep study. If an in-lab sleep study is performed without having been prior authorized, the member may be responsible for full payment of charges.

### **Selecting a Lab for In-Network Benefits (Winter 2019 – 2020)**

Blue Cross Blue Shield (BCBS) Association rules generally required providers to submit their bills for services to their "local" BCBS plan (i.e., the plan with geographic jurisdiction over the provider's practice whether or not the provider participates in BCBS). It has come to MCTWF's attention that an exception to that rule exists that members should be aware of. That exception provides that Claims for lab services from an independent, freestanding lab are to be billed to the ordering physician's (not the lab's) local BCBS plan, regardless of where the lab service is rendered. So, although the lab that you choose may be affiliated with a certain BCBS local plan, it may not be affiliated with the local BCBS plan of the ordering physician — and, if not, the lab claim will be deemed as out-of-network, subjecting you to higher cost-share and possible balance billing. While the lab should check this out before rendering you the service, it may fail to do so, or do so incorrectly, leaving you exposed. Therefore, MCTWF urges you to be careful to select a lab that participates in your ordering physician's local plan. If you have any questions, please contact MCTWF's Member Services Call Center at 800-572-7687.

### **Livongo Diabetes Management Program (Winter 2020 – 2021)**

MCTWF provides 100% coverage of charges in connection with the Livongo for Diabetes Program, a highly effective, comprehensive diabetes management program first introduced in March of 2020. If you are diabetic with diabetes-related claim history and medical coverage through the MCTWF Actives Plan or MCTWF Retirees Plan, you are eligible for the following benefits under the Livongo for Diabetes Program: • Livongo's free, easy-to-use, smart blood glucose meter uploads your readings to a private account—no more logbooks. The meter provides personalized tips after each reading to support you with diabetes management. • Free and unlimited strips and lancets at no cost to you shipped directly to your home. You can order additional strips and lancets from your Livongo meter. • While you are enrolled in the Program, you can stress less, knowing supplies are unlimited and always available at no cost to you. • Access to Certified Diabetes Educators for guidance about anything from nutrition to lifestyle changes. To sign up or to learn more about the Program, visit [join.livongo.com/MCTWF/greetings](http://join.livongo.com/MCTWF/greetings) or call Livongo Member Support at 1-800-945-4355 and have your registration code, "MCTWF" ready. Your medical records will be provided to Livongo by Blue Cross Blue Shield of Michigan only for this sole and express purpose. All protected health information is kept strictly confidential and maintained in accordance with HIPAA privacy and security requirements.

### **Omada Prediabetes Program (Winter 2020 – 2021)**

MCTWF provides 100% coverage of Omada Health's charges in connection with its digital health program; an innovative program that could help reduce your risk of prediabetes, type 2 diabetes, and heart disease. The Omada Prediabetes Program, offered since March 2020, is designed to aid in making the changes that matter most — whether that's around eating, engaging in physical activity, sleeping, or managing stress. Omada's Prediabetes Program inspires healthy habits to maintain over the long term. It combines the science of behavior change with unwavering personal support, thereby helping you reduce key risk factors for certain chronic diseases. The Program is available to all MCTWF Actives Plan and MCTWF Retirees Plan members, age 18 and older, who are eligible for MCTWF medical benefits and who are approved for enrollment based on an assessment of risk factors by Omada. A simple assessment is all that is needed to be approved. The Program provides: • A professional health coach to keep you on track • A wireless scale to monitor your progress • An interactive program that adapts

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to you • Weekly online lessons to educate and inspire and • A small support group of Program participants for real-time advice and encouragement. Learn more and apply to see if you are eligible at [omadahealth.com/mctwf](http://omadahealth.com/mctwf). Your participation and progress in Omada's Prediabetes Program are strictly confidential.

### **COVID-19 Vaccine Coverage (Winter 2020 – 2021)**

As with the seasonal flu vaccine, eligible MCTWF members will be covered in full for the cost of the COVID-19 vaccination under both their medical and prescription drug benefits, thereby expanding access to COVID-19 vaccine administered by local in-network retail pharmacies, when available.

### **Immunization Schedules for Children and Adults (Winter 2020 – 2021)**

MCTWF's medical policy for covered immunizations follows the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. These immunization schedules can be viewed on-line at [cdc.gov/vaccines/schedules](http://cdc.gov/vaccines/schedules). For more information about child and adult vaccines, visit [www.cdc.gov](http://www.cdc.gov) or call (800) 232-4636.

### **Women's Health and Cancer Rights Act of 1998 (Winter 2020-2021)**

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 (ERISA) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Under the Women's Health Act, group health plans offering mastectomy coverage (such as MCTWF) must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

### **CVS/caremark Select Medical Devices Exclusion (Winter 2020 – 2021)**

Effective January 1, 2021, certain "medical devices" for which alternatives exist over-the-counter or by prescription are excluded from MCTWF coverage due to their unjustifiable and unacceptable spike in retail price. These are not traditional medical devices such as syringes, insulin products, alcohol swabs, etc., but rather, dermatological products (such as creams, emulsions, and gels), wound dressings and artificial saliva products utilized by a tiny number of members, each of whom has been notified of this exclusion by CVS/caremark. Most of these products do not address an otherwise unmet clinical need, but are slightly different versions of readily available over the counter or prescription products. A list of these select medical devices can be found on MCTWF's website on the Info Link tab.

### **Immunization Schedules for Children and Adults (Fall 2021)**

MCTWF wants to keep our families safe and our medical policy for covered immunizations follows the recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. These immunization schedules can be viewed online at [cdc.gov/vaccines/schedules](http://cdc.gov/vaccines/schedules). For more information about child and adult vaccines, visit [www.cdc.gov](http://www.cdc.gov) or call (800) 232-4636.

### **Your Roadmap to Conquering Flu Season – Time to get your Flu Shot**

It's important to start thinking about what steps you can take now to avoid the flu this winter. While the flu shot is important every year, it has become crucial because of the COVID-19 pandemic. While a flu vaccine can't protect you from getting COVID-19, reducing the number of flu cases will provide more resources to care for those who become ill with COVID-19.

An annual flu shot is the best way to protect yourself and your family. This also helps protect vulnerable populations, such as the elderly, pregnant women and young children, since you won't pass the flu onto them. It takes around two weeks for the vaccine antibodies to develop and start protecting you from the flu, so the CDC recommends getting vaccinated early in the season, ideally by the end of October. If you aren't able to receive your shot by that deadline, don't just forget about it. It's still beneficial to receive the vaccine through January.

Getting a flu shot is just the first step in staying healthy this season. To further protect seasonal viruses from affecting you and your family follow these guidelines:

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- Wash your hands often. Lather up with soap and vigorously rub your hands together to kill germs. Can't wash with water and soap? Use an alcohol-based hand gel.
- When you sneeze or cough, cover your mouth and wash your hands before touching any surfaces.
- Avoid touching your face, since your mouth and nose are where germs enter your body.
- Clean surfaces in your home and office that could be contaminated with germs, like bathroom faucethandles and remote controls.
- Avoid contact with sick people. If you start to feel ill, go home to avoid infecting others.

According to the CDC, the flu kills between 12,000 and 56,000 people in the U.S. each year, and up to 35million people in the U.S. get sick with the flu.

**Where do you go to get a flu shot?** Your MCTWF coverage includes a free shot each year at a participating doctor's office (visit copayment may apply) or a participating pharmacy in your area. The variety of options allowsyou to pick the location that's most convenient for you and your dependents. To find a participating medical provider or pharmacy, go to [www.mctwf.org](http://www.mctwf.org) and follow the search directions under the Provider Networks page

or contact MCTWF's Member Services Call Center at 800-572-7687.

*Flu Information provided by BCBSM.*

### **Omada Provides Prediabetes Health Support for Eligible MCTWF Members (Fall 2021)**

There's never been a more important time to focus on personal health.

MCTWF, in partnership with Omada® and BCBSM, provides a digital health program that could help you reduce your risk of prediabetes, type 2 diabetes, and heart disease by helping you make the changes that matter most, whether that's around eating,activity, sleep, or stress — all at no cost to you.

Omada is a digital lifestyle program that inspires healthy habits you can live with long term.

It combines the science of behavior change with unwavering personal support, so you can make changes that actually stick.

It'san approach shown to reduce risk factors for certain chronic diseases.

The Omada Program is available to all MCTWF members, age 18 and older, who are eligible for MCTWF medical benefits and who are approved for enrollment based on an assessment of risk factors by Omada.

The program includes:

- A professional health coach to keep you on track.
- A wireless scale to monitor your progress.
- An interactive program that adapts to you.
- Weekly online lessons to educate and inspire.
- A small group of participants for real-time support.

**Learn more and apply to see if you're eligible at**

**[omadahealth.com/mctwf](http://omadahealth.com/mctwf).Livongo Provides Management Program to**

### **Members with Diabetes**

MCTWF has partnered with BCBSM and Livongo® to provide a new diabetes management program.

MCTWF is offering the Livongo for Diabetes Program through a series of flyers that are mailed by Livongo to MCTWF members over age 13 who are diabetic with diabetes-related claim history and medical coverage through the MCTWF Actives Plan or MCTWF Retirees Plan. Medical claim records will be provided by Blue Cross Blue Shield of Michigan for this sole and express purpose. All protected health information is kept strictly confidential and maintained in accordance with HIPAA privacy and security requirements.

The Program includes:

- Unlimited free strips and lancets shipped directly to the enrollee's door. Enrollees can order refills of strips and lancetsright from the Livongo glucometer.
- Better diabetes monitoring: Livongo's advanced glucometer uploads blood glucose readings to a private account. The meter also provides personalized tips after each reading to support diabetes management.

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- Expert support available 24/7: Certified Diabetes Educators are available if needed. They can discuss anything from nutrition to lifestyle changes and will reach out to individuals when a blood glucose reading is out of range, to help when it's needed most.

Enroll by visiting the site at [www.join.livongo.com/MCTWF](http://www.join.livongo.com/MCTWF).

### **MDLIVE Extends No Co-pay and Enhances Mental Health Services (Fall 2021)**

MDLIVE® puts a doctor where you are! Six years ago, MCTWF introduced a convenient service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE.

This telehealth service provides on-demand access to U.S. Board-certified physicians 24 hours per day, 7 days a week, by phone, secure video, or through MDLIVE's mobile app for smartphones and tablets.

Patients can discuss their symptoms with a doctor and prescriptions are sent immediately to the pharmacy of choice. At home or on the road, treatment can begin right away. Behavioral health consultations are available by appointment only and secure video is considered the best mode for this type of consultation.

Good news! MCTWF's Trustees have extended the \$0 copay policy for another year, through March 31, 2022.

MDLIVE recently announced the implementation of enhanced capabilities for the benefit of our members who contact MDLIVE at a time when they may be in a medical emergency and/or a behavioral health crisis.

This will include a streamlined process for MDLIVE physicians, behavioral health providers, nurses, and customer service personnel to connect patients immediately to 911 in their location, as well as working with third-party crisis specialists. These enhancements will support patients in promptly obtaining the level of care to meet their urgent needs.

MDLIVE also is adding the capability to transfer non-emergent patients requiring behavioral health de-escalation to third-party crisis specialists, ProtoCall, for immediate behavioral health intervention. These crisis specialists are behavioral health clinicians who are available 24/7 to handle situations, including patients in an escalated state or who appear to need immediate support. Following the intervention with the crisis specialist, MDLIVE will have visibility into the call outcomes and recommendations of the third-party crisis specialists.

MDLIVE care coordination will occur for continuity of care and ongoing behavioral health services through MDLIVE as clinically appropriate.

Download the MDLIVE mobile app from the App Store, get it on Google Play or link to it at our website at [www.mctwf.org](http://www.mctwf.org), under the Info Links tab. For more information, call 800-400-MDLIVE.

### **Omada Prediabetes Program (Winter 2021 – 2022)**

Make good health a habit! MCTWF offers an innovative program to members that could help reduce the risk of prediabetes, type 2 diabetes, and heart disease. The Omada® Prediabetes Program is designed to aid in making the changes that matter most, whether that involves eating, engaging in physical activity, sleeping, or managing stress.

Omada's Prediabetes Program inspires healthy habits to maintain for a lifetime. It combines the science of behavior change with unwavering personal support, thereby helping reduce key risk factors for certain chronic diseases.

The Program is available to all MCTWF Actives Plan and MCTWF Retirees Plan members, age 18 and older, who are eligible for MCTWF medical benefits and who are approved for enrollment based on an assessment of risk factors by Omada. A simple assessment is all that is needed to be approved.

The Program provides:

- A professional health coach to keep you on track.
- A wireless scale to monitor your progress.
- Interactive program that adapts to you.
- Weekly online lessons to educate and inspire, and;
- A small support group of program participants for real-time advice and encouragement.

Learn more and apply to see if you are eligible at [omadahealth.com/mctwf](http://omadahealth.com/mctwf). Your participation and progress in Omada are confidential and it does not share any personal health information with your employer.

**Livongo for Diabetes Management Program (Winter 2021 – 2022)**

Livongo for Diabetes® is a health benefit that makes living with diabetes easier by providing a free, connected blood glucose meter, unlimited strips and lancets, and coaching.

If you are diabetic with diabetes-related claim history and medical coverage through the MCTWF Actives Plan or MCTWF Retirees Plan, you are eligible for the following free benefits under the Livongo for Diabetes Program:

- Livongo’s easy-to-use, smart blood glucose meter: Your blood sugar readings are automatically saved to your secure account on the Livongo app. Tracking your readings is easier than ever
  - Free and unlimited strips and lancets: Worry less about running out of strips. Plus, order more right from your meter with the touch of a button
  - Personalized support: Expert coaches can provide tailored guidance on nutrition, activity, and living a healthy lifestyle.
- To sign up or to learn more about the Program, visit [join.livongo.com/MCTWF](http://join.livongo.com/MCTWF) or call Livongo Member Support at 1-800-945-4355 and have your registration code, “MCTWF” ready.

**MCTWF Extends \$0 Copay Policy for MDLIVE Telehealth Visits (Winter 2021 – 2022)**

MCTWF members have free access to a convenient service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE®. This telehealth service provides on-demand access to U.S. Board-certified physicians 24 hours per day, seven days a week, by phone, secure video, or through MDLIVE's mobile app for smartphones and tablets. Patients can discuss their symptoms with a doctor and prescriptions are sent immediately to the pharmacy of choice. At home or on the road, treatment can begin right away. Behavioral health consultations are available by appointment only and secure video is considered the best mode for this type of consultation.

MCTWF's Trustees are extending the \$0 copay policy for another year, through March 31, 2023.

Download the MDLIVE mobile app from the App Store, get it on Google Play or link to it at [www.mctwf.org](http://www.mctwf.org), under the Info Links tab. For more information, call 800-400-MDLIVE.

**MCTWF Extends \$0 Copay Policy for MDLIVE Telehealth Visits**

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**Women’s Health and Cancer Rights Act of 1998 (Winter 2021 – 2022)**

The Women’s Health and Cancer Rights Act (Women’s Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 (ERISA) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women’s Health Act, group health plans offering mastectomy coverage (such as MCTWF) must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

For more information on this topic, visit the Department of Labor webpage at [www.dol.gov/general/topic/health-plans/womens](http://www.dol.gov/general/topic/health-plans/womens).

## WEEKLY ACCIDENT AND SICKNESS BENEFITS

### **Weekly Accident & Sickness (A&S) Benefits Eligibility (Winter 2019 – 2020)**

Weekly Accident and Sickness (A&S) benefits provide disability income and eligibility for other benefit package components during the covered period of a disability. MCTWF Actives Plan members who are eligible under a benefit package that provides weekly A&S benefits, will receive such benefits only if the participant ceased work as the result of a non-occupational disability due to illness, non- auto-related injury (however, if auto-related, members do remain eligible for disability income benefits), or pregnancy. Beneficiaries (i.e., spouse and dependent children) are not eligible to receive this benefit. To qualify for A&S benefits, all five of the below requirements must be met. The participant must:

- have established eligibility; and
- be reported as an actively working employee of a contributing employer at the time the disability commenced; and
- have contributions paid on his behalf from the participating employer to cover the commencement of the disability (i.e. the date established) which means the date established by the medical provider upon which the participant first became disabled; and
- be losing time from work due to the disability, i.e., A&S benefits are not payable if the disability occurs while laid-off, on personal leave, on sanctioned strike or lockout, temporary work stoppage (strike or lockout); and
- under the regular care of a licensed physician who confirms the disability and submits a Participant Report of Disability form completed by the physician, participant, and employer when requested.

### **What happens if my MCTWF benefit package changes while I am collecting the Weekly A&S Benefit?**

Previously, if your MCTWF benefit package included weekly accident and sickness coverage, the benefits you received throughout your disability were those in effect at the time your disability commenced, regardless of whether, during your disability, your unit's benefit package changed. Effective November 1, 2019, MCTWF's Trustees have provided that if during your disability your unit's benefit package changes to an increased disability income amount, your disability income benefit will increase to that amount as of the effective date of the new benefit package.

## PRESCRIPTION DRUG BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

### **Notice of Creditable Coverage All MCTWF Benefit Packages with Prescription Drug Coverage (Fall 2015)**

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 all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, non-sedating antihistamines (until 12/31/15, thereafter not covered), proton pump inhibitors (effective 1/1/16, after a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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.

## Michigan Conference of Teamsters Welfare Fund

### **For more information about this notice or your current prescription drug coverage...**

Contact MCTWF'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 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](http://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](http://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, 2015

Michigan Conference of Teamsters Welfare Fund

Michigan Conference of Teamsters Welfare Fund

Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
Anti-infectives, Antivirals Herpes Agents	VALTREX	acycovir, valacyclovir
Anti-obesity Agents Newer Agents	QSYMIA	BELVIQ, CONTRAVE, SAXENDA
Asthma Beta Agonists, Short-Acting	PROVENTIL HFA XOPENEX HFA VENTOLIN HFA	PROAIR HFA,
Asthma Steroid Inhalants	AEROSPAN ALVESCO	ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
Asthma or Chronic Obstructive Pulmonary Disease (COPD) Steroid/Beta Agonist Combinations	SYMBICORT	ADVAIR, DULERA,
Attention Deficit Hyperactivity Disorder Agents	ADDERALL XR INTUNIV	amphetamine-dextroamphetamine mixed salts, amphetamine-dextroamphetamine mixed salts, ext- rel, guanfacine ext-rel, methylphenidate, methylphenidate ext-rel, DAYTRANA, QUILLVANT XR, STRATTERA, VYVANSE
Cardiovascular Antilipemics Fibrates	TRICOR	fenofibrate, fenofibric acid
Cardiovascular Antilipemics HMG Co-A Reductase Inhibitors (HMGs or Statins) / Combinations	ADVICOR LIPITOR ALTROPREV LIPTRUZET LESCOL XL LIVALO	atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, CRESTOR, SIMCOR, VYTORIN
Chronic Obstructive Pulmonary Disease (COPD) Anticholinergics	INCRUSE ELLIPTA TUDORZA	SPIRIVA
Depression Antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs)	CYMBALTA	duloxetine, venlafaxine, venlafaxine ext-rel, KHEDEZLA, PRISTIQ
Depression Antidepressants, Miscellaneous Agents	QLEPTRO	trazodone
Depression, Schizophrenia Antipsychotics, Atypicals	ABILIFY	aripiprazole, clozapine, olanzapine, quetiapine, risperdone, ziprasidone, LATUDA, SEROQUEL XR
Dermatology Actinic Keratosis	Fluorouracil cream 0.5% CARAC	fluorouracil cream 5%, fluorouracil soln, imiquimod, PICATO, ZYCLARA
Dermatology Rosacea	NORITATE	metonidazole, sulfacetamide-sulfur, FINACEA, SOOLANTRA
Dermatology Skin Inflammation and Hives Corticosteroids	clobetasol spray CLOBEX SPRAY OULX-E	clobetasol foam
	APEXICON E	desoximetasone, fluocinonide
Diabetes Biguanides	FORTAMET GLUMETZA RIOMET	metformin, metformin ext-rel
Diabetes Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	KAZANO OSENI KOMBIGLYZE XR	JANUMET, JANUMET XR, JENTADUETO
Diabetes Injectable Incretin Mimetics	BYDUREON BYETTA	TRULICITY, VICTOZA
Diabetes Insulins	APIDRA HUMALOG	NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30	NOVOLIN 70/30
	HUMULIN N	NOVOLIN N
	HUMULIN R	NOVOLIN R
	NOTE: Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered.	
Diabetes	ACTOS	pioglitazone
Insulin Sensitizers		

<b>Diabetes</b> Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA	JANUVIA, TRADJENTA	
<b>Diabetes</b> Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors	<b>INVOKANA</b>	FARXIGA, JARDIANCE	

**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.

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September 1, 2015

Michigan Conference of Teamsters Welfare Fund

Michigan Conference of Teamsters Welfare Fund

Drugs Requiring Prior Authorization – Fall 2015

Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
Diabetes Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitor/Biguanide Combinations	<b>INVOKAMET</b>	XIGDUO XR
<b>Diabetes Supplies</b>	ACCU-CHEK STRIPS AND KITS BREEZE 2 STRIPS AND KITS CONTOUR STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS FREESTYLE STRIPS AND KITS All other test strips that are not ONETOUCH brand	ONETOUCH ULTRA STRIPS AND KITS, ONETOUCH VERIO STRIPS AND KITS
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonists/ Diuretic combinations	ATACAND HCT      EDARBI DIOVAN              TEVETEN	<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, telmisartan- hydrochlorothiazide, valsartan-hydrochlorothiazide, BENICAR HCT</i>
<b>Erectile Dysfunction</b> Phosphodiesterase Inhibitors	LEVITRA <b>VIAGRA</b>	CIALIS
<b>Gastrointestinal Agents</b> Irritable Bowel Disease – Constipation Predominant	<b>AMITIZA</b>	LINZESS
<b>Glaucoma</b> Prostaglandin Analogs	LUMIGAN	<i>latanoprost, travoprost, TRAVNTANZ, ZIOPTAN</i>
<b>GROWTH HORMONES</b>	GENOTROPIN      OMNITROPE NUTROPINAQ      SAIZEN	HUMATROPE, NORDITROPIN
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonists	ATACAND      EDARBI <b>DIOVAN</b> TEVETEN	<i>candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan, BENICAR</i>
<b>High Blood Pressure</b> Angiotensin II Receptor Antagonist/ Calcium Channel Blocker /Diuretic Combinations	<b>EXFORGE HCT</b>	<i>amlodipine-valsartan-hydrochlorothiazide, TRIBENZOR</i>
<b>High Blood Pressure</b> <b>Calcium Channel Blockers</b>	NORVASC	<i>amlodipine</i>
	<b>CARDIZEM</b> <i>matzim LA</i> <b>CARDIZE, CD</b> <b>CARDIZEM LA (includes generic cardizem LA)</b>	<i>diltiazem ext-rel (except generic of cardizem LA)</i>
<b>Inflammatory Bowel Disease (IBD), Ulcerative Colitis</b> Aminosalicylates	ASACOL HD DELZICOL	<i>balsalazide, budesonide capsule, sulfasalazine, sulfasalazine delayed-rel, APRISO, LIALDA, PENTASA, UCERIS</i>
<b>Kidney Disease</b> Phosphate Binders	<b>FORSRENOL</b>	<i>calcium acetate, PHOSLYRA, RENVELA, VELPHORO</i>
<b>Multiple Sclerosis Agents</b>	<b>AVONEX</b> <b>PLEGRIDY</b> <b>EXTAVIA</b>	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF
<b>Musculoskeletal Agents</b>	AMRIX	<i>cyclobenzaprine</i>
<b>Opioid Dependence Agents</b>	<b>ZUBSOLV</b>	<i>buprenorphine-naloxone sublingual tablet, SUBOXONE FILM</i>
<b>Osteoarthritis</b> Viscosupplements	EUFLEXXA      ORTHOVISC <b>MONOVISC</b>	GEL-ONE, HYALGAN, SUPARTZ
<b>Pain and Inflammation</b> Nonsteroidal Anti-inflammatory Drugs (NSAIDs) Combinations	ARTHROTEC VIMOVO DUEXIS	<i>celecoxib; diclofenac, meloxicam, or naproxen WITH lansoprazole, omeprazole, omeprazole-sodium bicarbonate capsule, pantoprazole, DEXILANT, or NEXIUM</i>
	FLECTOR <b>PENNSAID</b>	<i>diclofenac, diclofenac sodium solution, meloxicam, naproxen, VOLTAREN GEL</i>
	<b>NAPRELAN</b>	<i>diclofenac, meloxicam, naproxen, CELEBREX</i>
<b>Prostate Condition</b> Benign Prostatic Hyperplasia Agents/Combinations	JALYN	<i>finasteride or AVODART WITH alfuzosin ext-rel, doxazosin, tamsulosin, terazosin or RAPAFLO</i>
<b>Transplant</b> Immunosuppressants, Calcineurin Inhibitors	Hecoria	<i>tacrolimus</i>

## Michigan Conference of Teamsters Welfare Fund

As was first announced in the winter 2011-2012 *Messenger*, MCTWF's pharmacy benefit manager, CVS/caremark, made prior authorization of prescription drugs that are not on its Standard Formulary list, a condition of coverage.

The following list reflects each such 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). Effective January 1, 2016, those drugs stated in bold are no longer formulary drugs and require prior authorization. CVS/caremark will so notify current utilizers of the newly added drugs and their prescribing physician and will provide them with a list of covered alternative drugs that are therapeutically equal in effectiveness. Please note that generic drugs are in *lowercase italics* font and brand drugs are in UPPERCASE roman font. To obtain prior authorization, your physician must contact CVS/caremark at 800-626-3046.

Common Condition/ Therapeutic Class	Drug Subject to Prior Authorization	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
<i>Allergic Reaction</i> (Anaphylaxis) Treatment	ADRENACLICK	AUVI-Q, EPIPEN, EPIPEN JR
<b>Allergies</b> Nasal Steroids/Combinations	BECONASE AQ      RHINOCORT AQUA OMNARIS            VERAMYST QNASL                ZETONNA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i>
	DYMISTA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i> <b>WITH</b> <i>azelastine spray</i> or PATANASE
<b>Allergies</b> Ophthalmic	LASTACFT	<i>azelastine, cromolyn sodium, PATADAY, PATANOL</i>
<b>Anti-infectives, Antivirals</b> Cytomegalovirus Agents	<b>VALCYTE</b>	<i>valganciclovir</i>
<b>Anti-infectives, Antivirals</b> Hepatitis C Agents	VIEKIRA PAK	HARVONI

### Non-Sedating Antihistamines and Proton Pump Inhibitors – Coverage Changes (Fall 2015)

Currently, in order to obtain coverage for prescription drugs classified as non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) prior authorization must be granted by MCTWF's Utilization Review Department based on evidence of satisfaction of certain documented criteria.

**Non-Sedating Antihistamines** – Effective with prescription fills on or after January 1, 2016, due to the universal availability of over-the-counter NSAs, MCTWF coverage will cease except that those patients who have an existing MCTWF authorization as of 12/31/15 will remain covered for the remainder of the authorization period, subject, of course, to otherwise maintaining eligibility for MCTWF prescription drug benefits.

**Proton Pump Inhibitors** – Effective with prescription fills on or after January 1, 2016, patients will be allowed 90 units of generic PPIs per 365-day period without needing prior authorization. For patients requesting brand PPIs, or treatment for longer than 90 days per 365-day period, prior authorization will be required and administered by CVS/caremark to determine whether medical necessity requirements are satisfied. Patients who have an existing MCTWF authorization as of 12/31/15 will remain covered for the remainder of the authorization period, subject, of course, to otherwise maintaining eligibility for MCTWF prescription drug benefits.

### Compound Drugs – Expanded Limitations on Coverage (Fall 2015)

As stated in the spring 2015 issue of the *Messenger* effective June 2015, in an effort to promote the use of safe, effective compounds, all compound drug claims exceeding \$300 are subject to review for medical appropriateness by CVS/caremark through consideration of prior authorization requests. Further all compound fills, regardless of the charge, are limited to one fill of the same compound per 34 days. The patient's physician must contact CVS/caremark at 800-626-3046.

In light of the recent explosion in the prices charged by unscrupulous compounding pharmacies for bulk powders and proprietary compounding bases, effective with prescription fills on or after January 1, 2016, limitations on coverage are expanded, as follows:

- coverage will be denied for proprietary compounding bases, bulk compounding powders, and compounding kits; and
- coverage will be excluded for select topical compounded analgesics (pain patches).

**CVS/caremark’s Advance Control Specialty Formulary Program (Fall 2015)**

Effective January 1, 2016, CVS/caremark’s Advance Control Specialty Formulary Program is expanding to cover a total of 11 therapeutic classes. As previously explained, this Program was designed to help address the extraordinary and rapidly growing cost of specialty drugs. It does so by limiting coverage to lower cost but equally effective specialty drugs in the same therapeutic class, as determined by step therapy. These therapeutic classes are -

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| 1. Autoimmune                     | 7. Osteoarthritis                   |
| 2. Chronic Myeloid Leukemia (CML) | 8. Osteoporosis                     |
| 3. Hematology                     | 9. Prostate Cancer                  |
| 4. Hepatitis C                    | 10. Pulmonary Arterial Hypertension |
| 5. Growth Hormone                 | 11. Transplant                      |
| 6. Multiple Sclerosis             |                                     |

If the patient is prescribed a specialty medication and goes to a retail pharmacy, the pharmacist will ask the patient to contact CVS/caremark at 800-237-2767 to initiate a direct relationship with CVS/caremark specialty pharmacy services.

**Opioid Use and Abuse (Spring 2016)**

The following text was excerpted, with permission, from a broader article entitled “Controlled Substance Strategies at CVS Health,” from its February 2016 issue of *Clinical Knowledge Management News for Clients*. Article footnotes were extensive and have been removed in the interest of space. The Fund is considering implementation of controlled substance management programs to better address this rampant problem.

**Opioid Medication Uses and Risks**

Prescription opioid medications are used to treat severe acute pain, such as from surgery or injury, and chronic pain from active cancer or at the end of life. Guidelines from the American Pain Society (APS) and American Academy of Pain Medicine (AAPM) state that chronic opioid therapy can also be an effective therapy for carefully selected and monitored patients with chronic noncancer pain. Some medications in this class include hydrocodone, oxycodone, morphine, methadone, buprenorphine, and codeine.

However, opioid medications are associated with dependence, tolerance, abuse, and risk of accidental overdose. One study found that death rates for drug overdoses involving opioids were 7.8 per 100,000 adults aged 18 through 64 years in 2013, an increase from 4.5 per 100,000 in 2003. The same study, which looked at nonmedical prescription opioid use and use disorders, also found increases in the prevalence of opioid use disorders and frequency of use during the same period although the prevalence of nonmedical use of prescription opioids decreased. Opioids can also have side effects, such as sleepiness and constipation. They can worsen pain, impair driving, and affect the immune system, and they are associated with a number of drug interactions.

**Overprescribing of Controlled Substances**

Overprescribing of controlled substances, such as opioids, is an area of concern. Health care providers wrote 258.9 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of these pills. While those in the United States constitute only 4.6 percent of the world’s population, they consume 80 percent of the global opioid supply and 99 percent of the global hydrocodone supply. According to the Centers for Disease Control and Prevention (CDC), overprescribing of opioids is associated with higher rates of drug overdose deaths and substance abuse treatment admissions.

In 2014, 6.5 million people aged 12 years or older reported nonmedical use of psychotherapeutic drugs—about two-thirds of those people were taking pain relievers non-medically. National Survey on Drug Use and Health data indicate that 53 percent of non-medical users of controlled prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) aged 12 or older obtained the prescription drugs they most recently used “from a friend or relative for free,” and 21.2 percent reported obtaining

them from “one doctor,” according to a recent report from the DEA. More than four in five of those who obtained prescription drugs from a friend or relative for free reported that their friend or relative had obtained the drugs from a single doctor. Strategies to address overprescribing are essential. For instance, the U.S. Department of Health and Human Services recommended looking at opioid prescribing practices to reduce opioid use disorders and overdose as one of the three priority areas they identified in an initiative to combat opioid abuse.

## Michigan Conference of Teamsters Welfare Fund

### Risk Factors for Adverse Outcomes in Opioid Abuse

A number of risk factors have been associated with adverse outcomes in opioid use, such as overdose and progression to substance abuse. We can pursue improved clinical outcomes through positively impacting the following measures of controlled substance use:

- Morphine equivalent dose (MED) greater than 120 mg/day, although risk also exists at lower doses. Determining MED is the process of converting from one opioid agent to an equivalent dose of another agent or changing the route of opioid administration using morphine as the reference standard. It is used for determining the dose when a patient is on one or more opioids;
- Use of opioids for greater than 90 days;
- Multiple prescribers and pharmacies; and
- Combinations of central nervous system depressants (such as benzodiazepines and other sedatives—hypnotics, antidepressants, and sleep aids—along with an opioid).

### CVS/caremark Standard Formulary Exclusions and Add-Backs (Fall 2016)

As was first announced in the winter 2011-2012 Messenger, MCTWF's pharmacy benefit manager, CVS/caremark, made prior authorization for medical necessity of prescription drugs that are excluded from its Standard Formulary list a condition of coverage. The following list reflects those drugs that, effective January 1, 2017, either are newly excluded from the Standard Formulary (and therefore require prior authorization), or have been returned to it (and therefore no longer require prior authorization). CVS/caremark is notifying current utilizers and their prescribing physician of the newly excluded drugs, and is providing them with a list of covered alternative drugs that are therapeutically equivalent. Please note that generic drugs are in lowercase italics font and brand drugs are in UPPERCASE roman font. To obtain prior authorization, your physician must contact CVS/caremark at 800-626-3046. Since the full list of drugs excluded from the Standard Formulary (and therefore requiring prior authorization) has become too lengthy for publication here, the list is published on our website at [www.mctwf.org](http://www.mctwf.org) (click on the Info Links page and view the list under CVS/Caremark).

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/17 (Subject to Prior Authorization)	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)	Drug Added Back to Standard Formulary Effective 1/1/17 (No Longer Subject to Prior Authorization)
<b>Allergies</b> Nasal Steroid/Combinations			DYMISTA
<b>Anti-infectives, Antivirals</b> Hepatitis C Agents	DAKLINZA OLYSIO TECHNIVIE ZEPATIER	EPLUSA, HARVONI, SOVALD	
<b>Asthma</b> Beta Agonists, Short-Acting	PROVENTIL HFA VENTOLIN HFA	PROAIR HFA, PROAIR RESPICLICK	
<b>Cancer</b> Chronic Myelogenous Leukemia Agents	GLEEVEC TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL	
<b>Cancer Prostate</b> Hormonal Agents, Antiandrogens	NILANDRON XTANDI	<i>bicalutamide</i> , ZYTIGA	
<b>Cardiovascular Antilipemics</b> HMG-CoA Reductase Inhibitors (HMGs or Statins) / Combinations	CRESTOR	<i>atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin, VYTORIN</i>	
<b>Cardiovascular</b> Potassium Supplements	KLOR-CON/25	<i>potassium chloride liquid</i>	
<b>Cardiovascular Pulmonary Arterial Hypertension Agents</b> Endothelin Receptor Antagonists	OPSUMIT	LETAIRIS, TRACLEER	

<b>Carnitine Deficiency Agents</b>	CARNITOR CARNITOR SF	<i>levocarnitine</i>	
<b>Cystic Fibrosis</b> Inhaled Antibiotics	TOBI TOBI PODHALER	<i>tobramycin inhalation solution,</i> BETHKIS	
<b>Depression</b> Antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs)	venlafaxine ext-rel tablet (except 225 mg)	<i>duloxetine, venlafaxine, venlafaxine ext- rel capsule, PRISTIQ</i>	

<b>Common Condition/ Therapeutic Class</b>	<b>Drug Newly Excluded from Standard Formulary Effective 1/1/17 (Subject to Prior Authorization)</b>	<b>Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</b>	<b>Drug Added Back to Standard Formulary Effective 1/1/17 (No Longer Subject to Prior Authorization)</b>
<b>Dermatology</b> Miscellaneous Skin Conditions	ALCORTIN A ALOQUIN NOVACORT	<i>hydrocortisone</i>	
<b>Diabetes</b> Long Acting Insulins	LANTUS TOUJEO	BASAGLAR, LEVEMIR, TRESIBA	
<b>Diabetes</b> Supplies, Pen Needles	ALLISON MEDICAL PEN NEEDLES NOVO NORDISK PEN NEEDLES ULTIMED PEN NEEDLES	BD PEN NEEDLES	
<b>Diabetes</b> Supplies, Syringes	ALLISON MEDICAL INSULIN SYRINGES TRIVIDIA INSULIN SYRINGES ULTIMED INSULIN SYRINGES	BD INSULIN SYRINGES	
<b>Gastrointestinal Agents</b> Irritable Bowel Disease - Constipation Predominant			AMITIZA
<b>Hematologic</b> Anticoagulants (oral)	PRADAXA	<i>warfarin, ELIQUIS, XARELTO</i>	
<b>Hematologic</b> Hemophilia Agents	HELIXATE FS	KOGENATE FS	
<b>Hematologic</b> Neutropenia Colony Stimulating Factors	NEUPOGEN	ZARXIO	
<b>Hematologic</b> Platelet Aggregation Inhibitors	PLAVIX	<i>clopidogrel, BRILINTA, EFFIENT</i>	
<b>High Blood Pressure</b> Beta-blocker Combinations	DUTOPROL	<i>metoprolol succinate ext-rel with hydrochlorothiazide</i>	
<b>Huntington's Disease Agents</b>	XENAZINE	<i>tetrabenazine</i>	
<b>Opioid Reversal Agents</b> Antagonists	EVZIO	NARCAN NASAL SPRAY	
<b>Overactive Bladder/Incontinence</b> Urinary Antispasmodics	ENABLEX GELNIQUE	<i>oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, MYRBETRIQ, TOVIAZ, VESICARE</i>	TOVIAZ
<b>Pain</b> Headache Agents	butalbital-acetaminophen-caffeine capsule	<i>naratriptan, rizatriptan, sumatriptan, zolmitriptan, RELPAX, ZOMIG</i>	

		NASAL SPRAY	
<b>Pain</b> Transmucosal Immediate-release Fentanyl Agents	ABSTRAL	<i>fentanyl transmucosal lozenge,</i> FENTORA, SUBSYS	
<b>Pain and Inflammation</b> Corticosteroids	DEXPAK MILLIPRED	<i>dexamethasone, methylprednisolone,</i> <i>prednisone</i>	
<b>Pain and Inflammation</b> Nonsteroidal Anti-inflammatory Drugs (NSAIDs)/Combinations			DUEXIS VIMOVO

**Notice of Creditable Coverage (Fall 2016)**

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 all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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.

## Michigan Conference of Teamsters Welfare Fund

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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (after a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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 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 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](http://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](http://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, 2016

### **Daily Low Dose Cialis Coverage Now Available Without Prior (Spring 2017)**

Effective, April 1, 2017, prescriptions for daily low dose (2.5 mg and 5 mg) Cialis are fillable without prior authorization and without diagnosis restrictions. The quantity limitation of 6 tablets every 34 days or 20 pills every 90 days for erectile dysfunction medications no longer applies to daily low dose (2.5 mg and 5 mg) Cialis prescriptions. The quantity limitation for all other erectile dysfunction medications continues.

**Coverage for Non-Insulin Syringes (Spring 2017)** MCTWF pharmacy benefits have provided coverage for "insulin" syringes when they are obtained from the pharmacy with a prescription medication, but have not provided coverage for "non-insulin" syringes except when required to inject specialty medications or when pre-filled with the prescription medication.

Effective May 4, 2017, all previously non-covered non-insulin syringes prescribed by your physician will be covered, subject to your pharmacy benefit brand copayment or coinsurance charge.

**Prior Authorization and 90 Day Limits for Lidocaine Prescriptions (Spring 2017)** MCTWF previously informed you of its implementation of CVS/caremark’s Core Compound Strategy program to address abuses engaged in by many compounding pharmacies in the past few years. Recently, CVS/caremark has seen an emerging trend of spiking costs and quantities billed by compounding pharmacies for lidocaine and lidocaine-containing formulations, presumably to replace some of the lost revenues that resulted from the success of the program. Lidocaine has many uses but is most commonly used topically for pain (such as with injection sites or minor surgical procedures), skin ulcers, burns, abrasions or insect bites. It can also be used for pain relief in accessible mucous membranes of the oral and nasal cavities. Lidocaine is an ingredient in both FDA-approved and unapproved products.

**Effective April 17, 2017**, FDA-approved products that are lidocaine or lidocaine-containing formulations will be subject to a prior authorization requirement after the first month’s fill and the authorization, if approved, will be limited to up to 90 days. Prior authorization can be obtained by having your physician contact CVS/caremark at (800) 237-2767. Targeted communications were sent to affected participants and physicians to help ensure that they are aware of these changes.

**CVS/caremark Standard Formulary Prescription Drug Updates (Winter 2017 – 2018)**

As was first announced in the winter 2011-2012 Messenger, MCTWF’s pharmacy benefit manager, CVS/caremark, made prior authorization for medical necessity of prescription drugs that are excluded from its Standard Formulary list a condition of coverage. The following list reflects those drugs (listed in bold), that effective January 1, 2018, are newly excluded from the Standard Formulary (and therefore require prior authorization), or have been returned to it (and therefore no longer require prior authorization). CVS/caremark has notified affected utilizers and their prescribing physician of the newly excluded drugs, and has provided them with a list of covered alternative drugs that are therapeutically equivalent. Please note that generic drugs are in lowercase italic font and brand drugs are in UPPERCASE roman font. To obtain prior authorization, your physician must contact CVS/caremark at 800-626-3046. Since the full list of drugs excluded from the Standard Formulary (and therefore requiring prior authorization) is too lengthy for publication here, the list is published on our website at [www.mctwf.org](http://www.mctwf.org) (click on the Info Links page and view the list under CVS/Caremark).

<b>Category/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Recommended Alternative Generic or Brand Drugs in Therapeutic Class</b> <i>(note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)</i>
Anti-infectives, Antivirals/ Hepatitis C	<b>MAVYRET</b>	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI
Anti-infectives, Antibacterials/ Tetracyclines	<b>MINOCIN</b>	<i>minocycline</i>
	<b>DORYX/DORYX MPC MONODOX</b>	<i>doxycycline hyclate</i>
Asthma or Chronic Obstructive Pulmonary Disease (COPD)/ Steroid/ Beta Agonist Combinations	<b>DULERA</b>	ADVAIR, BREO ELLIPTA, SYMBICORT
Cancer Prostate/ Hormonal Agents, Antiandrogens	<b>NILANDRON</b>	<i>bicalutamide</i> , XTANDI, ZYTIGA
Cardiovascular Antilipemics/ Cholesterol Absorption Inhibitors	<b>ZETIA</b>	<i>ezetimibe</i>
Chronic Obstructive Pulmonary disease (COPD)/ Anticholinergics	<b>TUDORZA</b>	INCRUSE ELLIPTA, SPIRIVA
Depression/ Antidepressants, Selective Norepinephrine Reuptake	<i>venlafaxine ext-rel tablet (except 225 mg)</i> <b>VENLAFAXINE EXT-REL TABLET (except 225 mg)</b> CYMBALTA	<i>desvenlafaxine ext-rel, duloxetine, venlafaxine, venlafaxine ext-rel capsule,</i>
Inhibitors (SNRIs)	<b>EFFEXOR XR</b>	

Depression and/or Schizophrenia/ Antipsychotics, Atypicals	ABILIFY FANAPT SEROQUELXR	<i>aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone, LATUDA, VRAYLAR</i>
Diabetes/ Injectable Incretin Mimetics	BYDUREON BYETTA TANZEUM	TRULICITY, VICTOZA
Diabetes/ Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors	<b>JARDIANCE</b>	FARXIGA, INVOKANA
<b>Category/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Recommended Alternative Generic or Brand Drugs in Therapeutic Class</b> (note: the below listed generics are <u>not</u> the direct generic equivalent of the brand drug that is subject to prior authorization)
Diabetes/ Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitor / Biguanide Combinations	<b>SYNJARDY SYNJARDY XR</b>	INVOKAMET, INVOKAMET XR, XIGDUO XR
Erectile Dysfunction/ Hormonal Agents, Antiandrogens	STENDRA VIAGRA	CIALIS
Gauche Disease	<b>ELELYSO</b>	CERDELGA, CEREZYME
Pain/ Headache	<i>butalbital-acetaminophen-caffeine capsule</i> <b>CAFERGOT FIORICET CAPSULE</b>	<i>eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
Migraine Injectable	<b>SUMAVEL DOSEPRO</b>	<i>eletriptan, naratriptan rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
High Blood Pressure/ Angiotensin II Receptor Antagonists	ATACAND <b>BENICAR</b> DIOVAN EDARBI	<i>candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan</i>
High Blood Pressure/ Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT BENICAR HCT DIOVAN HCT EDARBYCLOR	<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide</i>
Multiple Sclerosis Agents	EXTAVIA	<i>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA</i>
Narcolepsy/ Wakefulness Promoters	<b>NUVIGIL</b>	<i>ardafinil</i>
Overactive Bladder/Incontinence/ Urinary Antispasmodics	DETROL LA ENABLEX OXYTROL	<i>oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, MYRBETRIQ, TOVIAZ, VESICARE</i>
Osteoarthritis/ Viscosupplements	EUFLEXXA <b>HYALGAN</b> MONOVISC ORTHOVISC" <b>SYNVISC SYNVISC ONE</b>	GEL-ONE, SUPARTZ FX
Post-Herpetic Neuralgia	<b>HORIZANT</b>	<i>gabapentin, GRALISE</i>
Testosterone Replacement/ Androgens	testosterone gel 1% ANDROGEL 1% FORTESTA NATESTO TESTIM VOGELXO	<i>testosterone gel 2%, testosterone solution, ANDRODERM, ANDROGEL 1.62%</i>
Pain/ Headache	<i>butalbital-acetaminophen-caffeine capsule</i> <b>CAFERGOT FIORICET CAPSULE</b>	<i>eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
Migraine Injectable	<b>SUMAVEL DOSEPRO</b>	<i>eletriptan, naratriptan rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
High Blood Pressure/ Angiotensin II Receptor Antagonists	ATACAND <b>BENICAR</b> DIOVAN EDARBI	<i>candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan</i>

High Blood Pressure/ Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT BENICAR HCT DIOVAN HCT EDARBYCLOR	<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide</i>
Multiple Sclerosis Agents	EXTAVIA	<i>glatiramer, AUBAGIO, BETASERON, COPAXONE 40 MG, GILENYA, REBIF, TECFIDERA</i>
Narcolepsy/ Wakefulness Promoters	NUVIGIL	<i>aradafinil</i>
<b>Category/ Therapeutic Class</b>	<b>Drug Subject to Prior Authorization</b>	<b>Recommended Alternative Generic or Brand Drugs in Therapeutic Class</b> (note: the below listed generics are <b>not</b> the direct generic equivalent of the brand drug that is subject to prior authorization)
Overactive Bladder/Incontinence/ Urinary Antispasmodics	DETROL LA ENABLEX OXYTROL	<i>oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, MYRBETRIQ, TOVIAZ, VESICARE</i>
Osteoarthritis/ Viscosupplements	EUFLEXXA HYALGAN MONOVISC ORTHOVISC" SYNVISC SYNVISC ONE	GEL-ONE, SUPARTZFX
Post-Herpetic Neuralgia	HORIZANT	<i>gabapentin, GRALISE</i>
Testosterone Replacement/ Androgens	testosterone gel 1% ANDROGEL 1% FORTESTA NATESTO TESTIM VOGELXO	<i>testosterone gel 2%, testosterone solution, ANDRODERM, ANDROGEL 1.62%</i>

### Notice of Creditable Coverage All MCTWF Benefit Packages with Prescription Drug Coverage(Winter 2017 - 2018)

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 all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (after a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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 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 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](http://www.medicare.gov) Visit [www.medicare.gov](http://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](http://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, 2017

Michigan Conference of Teamsters Welfare Fund

**Notice of Creditable Coverage (Winter 2019 – 2020)**

**All MCTWF Actives Plan and MCTWF Retirees Plan Prescription Drug Coverage**

The following Notice is published in accordance with regulations enacted 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.

- 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.
- MCTWF has determined that the prescription drug coverage offered by all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (longer than a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), FDA-approved products that are lidocaine or lidocaine-containing formulations (after the first month's fill), dosage, duration and other criteria based fills for opioids and buprenorphine mono products, anabolic

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steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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 also should 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 (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 (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 Member Services Call Center at (313) 964-2400 or (800) 572-7687. NOTE: You'll receive this notice each year. You also will get one before the next period you can join a Medicare drug plan or if this coverage through MCTWF changes. You may request a copy of this notice at any time.

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

Detailed information about Medicare plans offering prescription drug coverage is in the "Medicare & You" handbook. You should receive a copy of the handbook in the mail each year from Medicare. You also may be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://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](http://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, 2019**

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**Opioid Utilization Management Strategy (Winter 2017-2018)**

Effective February 1, 2018, MCTWF’s Pharmacy Benefits Manager, CVS/caremark, is administering on MCTWF’s behalf its Opioid Utilization Management Strategy. This clinical program, which is based upon the Centers for Disease Control and Prevention’s opioid prescribing benchmarks, is designed to strike a balance between legitimate and at-risk opioid use. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the likelihood of misuse, abuse, or overdose from these drugs. The program entails monitoring (prospective and retrospective reviews) of opioid medication utilization, prescriber management, network pharmacy evaluation and outreach, and utilization management of opioid medications as follows:

Utilization Management of Opioids	
Morphine Milligram Equivalent (MME) Based Quantity Limits	<ul style="list-style-type: none"> <li>• New initial limits for obtaining opioids without prior authorization up to 90 MME/day.</li> <li>• Quantities higher than initial limits require post-limit prior authorization; limited to a maximum of 200 MME/day.</li> </ul>
Prior Authorization Post-Quantity Limit Coverage Duration	<ul style="list-style-type: none"> <li>• Post-limit prior authorization approvals: 1 month for acute pain; 12 months for chronic pain.</li> <li>• Prescriber to reassess patient response at least every three months.</li> <li>• Duration not limited for patients fighting cancer.</li> </ul>
Step Therapy for Extended Release/Long-Acting Opioid Analgesics for Chronic Pain	<ul style="list-style-type: none"> <li>• For extended-release opioid, trial and failure of immediate release opioid is first required.</li> <li>• Requires prior authorization if claim history has no prior use of an immediate release opioid, or if not already stable on an extended-release opioid.</li> </ul>
10-Day Supply Duration Limit For Treatment of Acute Pain	<ul style="list-style-type: none"> <li>• Immediate release opioids for acute pain limited to 10-day supply.</li> <li>• Beyond 10 days, additional supply provided when coverage conditions are met through prior authorization.</li> </ul>
Increase Access to Treat Opioid Addiction	<ul style="list-style-type: none"> <li>• Remove prior authorization (retain quantity limits) for buprenorphine combo products (buprenorphine-naloxone).</li> <li>• Prior authorization with quantity limits in place for buprenorphine mono products. Emergency supply is permitted when authorization is processed.</li> </ul>

**Disposal of Unused Medications: What You Should Know (Winter 2017-2018)**

The following is excerpted from the U.S Food & Drug Administration’s website:

**Transfer Unused Medicine to Authorized Collectors for Disposal**

Consumers and caregivers should remove expired, unwanted, or unused medicines from their home as quickly as possible to help reduce the chance that others may accidentally take or intentionally misuse the unneeded medicine.

Medicine take-back programs are a good way to safely dispose of most types of unneeded medicines. The U.S. Drug Enforcement Administration (DEA) periodically hosts National Prescription Drug Take-Back events where collection sites are set up in communities nationwide for safe disposal of prescription drugs. Local law enforcement agencies may also sponsor medicine take-back programs in your community. [Note: For example, in Michigan, all 29 Michigan State Police posts now serve as locations to discard expired or unused medications. No appointment is necessary. This service is available Monday through Friday from 8 a.m. to 4 p.m. (excluding holidays). Be aware that medical liquids, inhalers, patches, or syringes are not accepted.] Likewise, consumers can contact their local waste management authorities to learn about medication disposal options and guidelines for their area.

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Another option for consumers is to transfer unused medicines to collectors registered with the DEA. Your community, authorized collection sites may be retail pharmacies, hospital or clinic pharmacies, and law enforcement locations. Some authorized collection sites may also offer mail-back programs or collection receptacles, sometimes called “drop-boxes,” to assist consumers in safely disposing of their unused medicines. Consumers can visit the DEA’s website for more information about drug disposal, National Prescription Drug Take-Back Day events and to locate a DEA-authorized collector in their area. Consumers may also call the DEA Office of Diversion Control’s Registration Call Center at 1-800-882-9539 to find an authorized collector in their community.

### **Disposal in Household Trash**

If no medicine take-back programs or DEA-authorized collectors are available in your area, and there are no specific disposal instructions on the label, such as flushing, you can also follow these simple steps to dispose of most medicines in the household trash: mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, kitty litter, or used coffee grounds; place the mixture in a container such as a sealed plastic bag; throw the container in your household trash; scratch out all personal information on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable; and then dispose of the container.

### **Enhanced Opioid Utilization Management Strategy (Winter 2019-2020)**

As part of MCTWF’s effort to address opioid abuse or misuse, it has authorized CVS/Caremark® to employ a new strategy designed to provide further protection for children and adolescents, age 19 and younger, by restricting those who are “opioid naïve” (i.e., having been prescribed opioids for seven days or fewer in the past 90 days) to a supply of three days or less of short-acting opioids. This strategy aligns with the Guideline for Prescribing Opioids for Chronic Pain from the Centers for Disease Control and Prevention (CDC).

CVS/Caremark continues to seek improvements in the way opioids are prescribed through clinical practice guidelines that ensure patients have access, while balancing the need for these medications, with the risk of abuse or misuse. For patients, whose clinical diagnosis may require a longer duration for ongoing therapy, the prescribing physician must contact CVS/Caremark at 800-626-3046 and obtain prior authorization.

### **Notice of Creditable Coverage All MCTWF Benefit Packages with Prescription Drug Coverage (Winter 2019-2020) All MCTWF Actives Plan and MCTWF Retirees Plan Prescription Drug Coverage**

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

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**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?**

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September 1, 2019

Michigan Conference of Teamsters Welfare Fund

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September 1, 2020

Michigan Conference of Teamsters Welfare Fund

### **Flu Shot and Affordable Care Act (ACA) Vaccines Now Available Under Prescription Drug Benefit At Network Pharmacies (Winter 2020-2021)**

On September 16, 2020, MCTWF mailed to you the following notification: It is particularly important that we avoid becoming infected with influenza during the COVID-19 pandemic. The Trustees of the Michigan Conference of Teamsters Welfare Fund (MCTWF) have determined that, effective September 30, 2020, seasonal flu vaccination administered by your network pharmacy (nationwide, there are over 68,000 retail pharmacies in the network that perform vaccinations) will be covered at no cost to you under your MCTWF prescription drug benefit. This will expand your access to the seasonal flu vaccine and eliminate any concern about your pharmacy's unwillingness or inability to bill the vaccination as a medical claim. Coverage under your MCTWF medical benefits remains available as well. This expansion of your prescription drug coverage also applies to all preventive care vaccines as provided for under the Affordable Care Act (ACA). Please see the list of covered vaccines below: Seasonal Vaccines: Injectable Seasonal Influenza Vaccine (Quadrivalent) • Intranasal Seasonal Influenza Vaccine (FluMist) • Injectable Seasonal Influenza Vaccine HighDose • Intradermal Influenza Vaccine Quadrivalent (Short Needle) and Flublok. As with the seasonal flu vaccine, eligible MCTWF members will be covered in full for the cost of the COVID-19 vaccination under both their medical and prescription drug benefits, thereby expanding access to COVID-19 vaccine administered by local in-network retail pharmacies, when available. COVID-19 Vaccine Coverage ACA Preventive Care Vaccines – Adults: Zoster (Shingles) • Tetanus, Diphtheria Toxoids • Hepatitis A & B. ACA Preventive Care Vaccines – Children: Haemophilus B • Haemophilus B, Hepatitis B • Inactivated Poliovirus • Rotavirus • Meningococcal, Haemophilus B, Tetanus • Measles, Mumps, Rubella, Varicella • Diphtheria, Tetanus • Diphtheria, Tetanus, Pertussis • Diphtheria, Tetanus, Pertussis, Haemophilus B • Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus • Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Haemophilus B • Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Hepatitis B. ACA Preventive Care Vaccines – Adults and Children: Pneumonia • Hepatitis A • Hepatitis B • Human Papillomavirus • Varicella • Measles, Mumps, Rubella • Meningococcal • Tetanus • Tetanus, Diphtheria, Pertussis. Seasonal flu and other preventive care vaccines may not always be available at the network pharmacy of your choice, so consider calling for availability (you also can search [www.caremark.com](http://www.caremark.com) to find a network "vaccine pharmacy") and to make an appointment. Please remember to present your white MCTWF Networks Card at the pharmacy.

**PrudentRx Copay Program for Specialty Medications (Winter 2020-2021)**

If you're taking specialty medications for a chronic or complex condition, you may be aware of how costly those medications can be – not only to you in payment of copay or coinsurance charges, but to MCTWF as well. Effective January 1, 2021, the MCTWF Actives Plan and the MCTWF Retirees Plan are offering to their specialty drug utilizers the opportunity to be relieved of all covered specialty drug out-of-pocket costs through automatic enrollment, subject to the member's right to opt out, in the PrudentRx Copay Program and then, with PrudentRx's assistance, by signing up for specialty drug manufacturer copay assistance, which MCTWF then uses to reduce its cost for the medication and to eliminate the utilizer's entire out-of-pocket expense for that medication. MCTWF's pharmacy benefit manager, CVS/caremark, has partnered with PrudentRx to make this Program available to its clients. In order to meet the goals of the PrudentRx Copay Program, MCTWF must set a coinsurance rate of 30% of the cost of the specialty medication, to be charged to utilizers who opt out of the Program or fail to sign up for the specialty drug manufacturer's copay assistance when requested by PrudentRx. If there is no manufacturer copay assistance program for your medication, your cost still will be \$0 if you are enrolled in the PrudentRx Copay Program. Specialty medications will continue to be filled exclusively by the CVS Specialty pharmacy and all specialty medications continue to require prior authorization. For medications not covered under the PrudentRx Copay Program, your out-of-pocket cost will continue to be in accordance with the standard prescription drug copay or coinsurance charges required by your MCTWF benefit package. If you are currently taking one or more medications included in the MCTWF Exclusive Specialty Drug List, you will receive a welcome letter and follow up phone call from PrudentRx approximately one week later providing specific information about the Program as it pertains to your medication(s). A PrudentRx patient advocate will help you sign up for the necessary specialty drug manufacturer copay cards. It is important to reiterate that if you choose to opt out of the Program, or fail to sign up for the specialty drug manufacturer's copay assistance, when requested by PrudentRx, you will be responsible for the full 30% specialty medication coinsurance charge. If you or a covered family member are not currently taking, but will be starting use of a new specialty medication, you can reach out to PrudentRx patient advocate for guidance at 800-578-4403 or await their outreach following CVS Specialty pharmacy approval of your prior authorization request. Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these nonqualifying medications, whether made by you or a manufacturer copayment assistance program, do not count towards MCTWF's Affordable Care Act annual outof-pocket maximums. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available on appeal for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual. The MCTWF Member Services Call Center is available Monday through Friday from 8:30 a.m. to 5:45 p.m. (eastern time) at (313) 964- 2400 or (800) 572-7687 for inquiries.

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CVS/caremark Standard Formulary Exclusions and Additions (Winter 2020-2021)

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/21 (Subject to Prior Authorization)	Recommended 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)	Drug Added Back to Standard Formulary Effective 1/1/21 (No Longer Subject to Prior Authorization)
Acromegaly	SANDOSTATIN LAR DEPOT, SIGNIFOR LAR, SOMAVERT	SOMATULINE DEPOT	
Anticonvulsants	APTIOM, BRIVIACT, FYCOMPA	carbamazepine, carbamazepine ex-trel, divalproex sodium, divalproex sodium ex-trel, gabapentin, lamotrigine, lamotrigine ex-trel, levetiracetam, levetiracetam ex-trel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, primidone, tiagabine, topiramate, valproic acid, zonisamide, OXTELLAR XR, TROKENDI XR, VIMPAT, XCOPRI	LAMICTAL (non-preferred)
Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRI)	PAXIL/ PAXIL CR, PEXEVA, VIIBRYD	citalopram, escitalopram, fluoxetine (except fluoxetine tablet 60 mg, fluoxetine tablet [generics for SARAFEM]), paroxetine HCl, paroxetine HCl ext-rel, sertraline, TRINTELLIX	
Anti-infectives, Antimalarial	DARAPRIM	pyrimethamine	
Attention Deficit Hyperactivity Disorder	ADZENYS ER/ XR-ODT, APTENSIO XR DAYTRANA	amphetamine-dextroamphetamine mixed salts ext-rel, methylphenidate ext-rel, MYDAYIS, VYVANSE	
Cancer, Multiple Myeloma Proteasome Inhibitors	BORTEZOMIB, KYPROLIS	NINLARO, VELCADE	
Cardiovascular, Nitrates	isosorbide dinitrate 40MG	isosorbide dinitrate (except isosorbide dinitrate 40mg), isosorbide mononitrate	
Cardiovascular, Pulmonary Arterial Hypertension Endothelin Receptor Antagonists	TRACLEER	ambrisentan, bosentan, OPSUMIT	
Chronic Obstructive Pulmonary Disease (COPD), Anticholinergics	INCRUSE ELLIPTA	SPIRIVA, YUPELRI	
Chronic Obstructive Pulmonary Disease (COPD), Anticholinergic/ Beta Agonist Combinations, Long Acting	BEVESPI AEROSPHERE	ANORO ELLIPTA, STIOLTO RESPIMA	
Contraceptives, Vaginal	NUVARING	ethinyl estradiol- etonogestrel, ANNOVERA	
Depression and/or Schizophrenia, Antipsychotics, Atypicals	INVEGA SUSTENNA	ABILIFY MAINTENA, PERSERIS	
Dermatology, Acne	AZELEX, DIFFERIN LOTION, FABIOR, TAZORAC	adapalene, benzoyl peroxide, clindamycin gel (except NDC <sup>6</sup> 68682046275), clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin, EPIDUO, ONEXTON	
Dermatology, Antipsoriatics	calcipotriene/betamethasone	calcipotriene ointment, calcipotriene solution WITH desoximetasone, fluocinonide (except fluocinonide cream 0.1%) or BRYHALI	
Dermatology, Rosacea	doxycycline monohydrate delayed-rel capsule, MIRVASO	ORACEA azelaic acid gel, metronidazole, FINACEA FOAM, SOOLANTRA	
Diabetes Long-Acting Insulins			TOUJEO (preferred)

## Michigan Conference of Teamsters Welfare Fund

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/21 (Subject to Prior Authorization)	Recommended 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)	Drug Added Back to Standard Formulary Effective 1/1/21 (No Longer Subject to Prior Authorization)
Diabetes Test Strips and Kits	ACCU-CHEK AVIVA PLUS*, ACCU-CHEK COMPACT PLUS*, ACCU-CHEK GUIDE*, ACCU-CHEK SMARTVIEW*	ONETOUCH ULTRA, ONETOUCH VERIO	ONETOUCH ULTRA, ONETOUCH VERIO (preferred)
Gastrointestinal, Irritable Bowel Syndrome	AMITIZA, TRULANCE*	LINZESS, MOVANTI, SYMPROIC, LINZESS	
Gastrointestinal, Laxatives	GOLYTELY, SUPREP	peg 3350-electrolytes, CLENPIQ	
Growth Hormones	HUMATROPE	GENOTROPIN, NORDITROPIN	NORDITROPIN (preferred)
Hematologic, Neutropenia Colony Stimulating Factors	NEULASTANEULASTA ONPRO, UDENYCA	ZIEXTENZO	
Menopausal Symptom Agents	ESTRING, FEMRING, INTRAROSA, PREMARIN CREAM, MENHEST, OSPHENA, PREMARIN	estradiol, IMVEXXY estradiol	
Multiple Sclerosis	TECFIDERA	dimethyl fumarate delayed-rel, glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, KESIMPTA, MAYZENT, OCREVUS, REBIF, TYSABRI, VUMERITY, ZEPOSIA	
Musculoskeletal	metaxalone 400mg	cyclobenzaprine (except cyclobenzaprine 7.5mg)	
Ophthalmic, Allergies	BEPREVE	azelastine, cromolyn sodium, olopatadine, LASTACAPT, PAZEO	
Ophthalmic, Anti-inflammatory, Nonsteroidal	PROLENSA	bromfenac, diclofenac, ketorolac, ACUVAIL, ILEVRO, NEVANAC	
Ophthalmic, Anti-inflammatory, Steroidal			FLAREX (non-preferred)
Ophthalmic, Antivirals	ZIRGAN	trifluridine	
Ophthalmic, Dry Eye Disease	LACRISERT	RESTASIS, XIIDRA	
Osteoarthritis, Viscosupplements	GEL-ONE, VISCO-3	DUROLANE, EUFLEXXA, GELSYN-3, SUPARTZFX	EUFLEXXA (preferred)
Otic, Anti-infective/Anti-inflammatory	CIPRO HC, CIPRODEX	ciprofloxacin- dexamethasone, ofloxacin otic	
Pain, Opioid Analgesics	oxymorphone ext-rel	fentanyl transdermal, hydrocodone ext-rel, hydromorphone ext-rel, methadone, morphine ext-rel, NUCYNTA ER, XTAMPZA ER	
Parkinson's Disease	APOKYN	INBRIJA	
Respiratory, Alpha-1 Antitrypsin Deficiency Agents	ARALAST NP, GLASSIA	PROLASTIN-C	

\*Current utilizers as of 12/31/20 will continue to be able to fill these prescriptions until advised otherwise, in writing by CVS/caremark. New utilizers as of 01/01/21 must use the Alternative Brandproducts in the Therapeutic Class listed.

**Notice of Creditable Coverage All MCTWF Benefit Packages with Prescription Drug Coverage (Fall 2021)**

**All MCTWF Actives Plan and MCTWF Retirees Plan Prescription Drug Coverage**

The following Notice is published in accordance with regulations enacted 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 all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is 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 certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (longer than a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), FDA-approved products that are lidocaine or lidocaine-containing formulations (after the first month's fill), dosage, duration and other criteria based fills for opioids and buprenorphine mono products, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, 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 also should 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 (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 (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 Member Services Call Center at (313) 964-2400 or (800) 572-7687. NOTE: You'll receive this notice each year. You also will get one before the next period you can join a Medicare drug plan or if this coverage through MCTWF changes. You may request a copy of this notice at any time.

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

Detailed information about Medicare plans offering prescription drug coverage is in the "Medicare & You" handbook. You should receive a copy of the handbook in the mail each year from Medicare. You also may be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://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](http://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, 2021

Michigan Conference of Teamsters Welfare Fund

**CVS/Caremark Standard Formulary Exclusions and Additions (Winter 2021 – 2022)**

The following list reflects those prescription medications that, effective January 1, 2022, are either newly excluded from CVS/Caremark's Standard Formulary (and therefore require prior authorization to establish medical necessity) or have been added to the Standard Formulary. Please note that listed generic drugs are in lowercase font and brand drugs are in UPPERCASE font. CVS/Caremark will be notifying current utilizers and their prescribing physician of the newly excluded drugs and is providing them with a list of covered alternative drugs that are therapeutically equivalent. To obtain prior authorization, your physician must contact CVS/Caremark at 800-626-3046.

Since the full list of drugs excluded from or added to the Standard Formulary in prior years has become too lengthy for publication here, the all-inclusive list is published on our website at [www.mctwf.org](http://www.mctwf.org) (click on the Info Links page. View the list under CVS/Caremark).

## Michigan Conference of Teamsters Welfare Fund

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/22 (Subject to Prior Authorization)	Recommended 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)	Drug Added Back to Standard Formulary Effective 1/1/22 (No Longer Subject to Prior Authorization)
Allergies, Nasal Steroids/Combinations	DYMISTA*	azelastine-fluticasone, flunisolide, fluticasone, mometasone	
Anaphylaxis Agents	ADRENALIN, SYMJEPi	epinephrine auto-injector, AUVI-Q, EPIPEN, EPIPEN JR	
Anticoagulants, Oral	ELIQUIS	warfarin, XARELTO	
Antifungals	tavaborole solution 5%	terbinafine tablet	
Anti-infectives, Antibacterials, Tetracyclines	doxycycline hyclate delayed-rel tablet (75 mg, 80 mg, 150 mg)*	doxycycline hyclate 20 mg, doxycycline hyclate capsule, minocycline, tetracycline	
Antiretroviral Combinations	ATRIPLA, COMPLERA	efavirenz-emtricitabine-tenofovir disoproxil fumarate, efavirenz-lamivudine-disoproxil fumarate, BIKTARVY, DOVATO, GENVOYA, ODEFSEY, STRIBILD, SYMTUZA, TRIUMEQ	
	TRUVADA	abacavir-lamivudine, emtricitabine-tenofovir disoproxil fumarate, CIMDUO, DESCOVY, TEMIXYS	
Asthma, Beta Agonists, Short-Acting	albuterol sulfate CFC-free aerosol (NDC 66993001968)*	albuterol sulfate CFC-free aerosol (except NDC 66993001968), levalbuterol tartrate CFC-free aerosol	
Botulinum Toxins	BOTOX (MEDICAL)	Consult doctor	
Cancer, Chronic Myelogenous Leukemia Kinase Inhibitors	ICLUSIG	imatinib mesylate, BOSULIF, SPRYCEL	
Cancer, mTOR Inhibitors	AFINITOR	everolimus, AFINITOR DISPERZ	
Cancer, Non-Small Cell Lung, Cancer, ALK Inhibitors	XALKORI	ALECENSA, ALUNBRIG, ZYKADIA	
Central Precocious Puberty			LUPRON DEPOT-PED (preferred)
Contraceptives	BALCOLTRA	ethinyl estradiol-drospirenone, ethinyl estradiol-drospirenone-levomefolate, ethinyl estradiol-levonorgestrel, ethinyl estradiol- norethindrone acetate, ethinyl estradiol- norethindrone acetate-iron, ethinylestradiol- norgestimate, LO LOESTRIN FE, NATAZIA	NATAZIA (preferred)
Dermatology, Acne	adapalene pad*	adapalene, benzoyl peroxide, clindamycin gel (except NDC^ 68682046275), clindamycin solution, clindamycin- benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin, EPIDUO, ONEXTON	
Dermatology, Rosacea	ivermectin cream 1%		SOOLANTRA CREAM
Dermatology, Skin Inflammation and Hives, Low Potency Corticosteroids	desonide gel, DesRx*	desonide (except desonide gel), hydrocortisone	

## Michigan Conference of Teamsters Welfare Fund

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/22 (Subject to Prior Authorization)	Recommended 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)	Drug Added Back to Standard Formulary Effective 1/1/22 (No Longer Subject to Prior Authorization)
Endocrine and Metabolic, Corticosteroids	prednisolone solution (10mg/5mL, 20mg/5mL)*	dexamethasone, hydrocortisone, methylprednisolone, prednisolone solution (except prednisolone solution 10 mg/5 mL, 20 mg/5 mL), prednisone	
Gastrointestinal, IrritableBowel Syndrome	budesonide ER tablets 9mg		UCERIS TABLET
Gastrointestinal, Laxatives	peg 3350-electrolytes (generics for MOVIPREP only)*	peg 3350-electrolytes (except generics for MOVIPREP), CLENPIQ	
Hematologic, Erythropoiesis- Stimulating Agents	ARANESP	RETACRIT	
Hematologic, Miscellaneous Bleeding Disorders Agents	FEIBA	NOVOSEVEN RT, SEVENFACT	
Hematologic, Neutropenia Colony Stimulating Factor	LEUKINE	NIVESTYM	
Hematologic, Thrombocytopenia Agents	MULPLETA	Consult doctor	
	NPLATE	PROMACTA, TAVALISSE	
Hereditary Angioedema	CINRYZE, HAEGARDA	ORLADEYO, TAKHZYRO	
High Blood Pressure, ACE Inhibitors	EPANED*	enalapril, fosinopril, lisinopril, quinapril, ramipril	
Immunologic Agents			HAEGARDA (non-preferred)*
Multiple Sclerosis			AVONEX (preferred), PLEGRIDY (non-preferred)
Otic, Anti-infective/ Anti- inflammatory	ciprofloxacin-fluocinolone (otic)*	ciprofloxacin-dexamethasone, ofloxacin otic	
Overactive Bladder/ Incontinence, Urinary Antispasmodics	MYRBETRIQ*	darifenacin ext-rel, oxybutynin ext-rel, solifenacin, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, GEMTESA, TOVIAZ	
Pain, Headache	butalbital-acetaminophen capsule, butalbital-acetaminophen tablet 25-325mg, Vtol LQ*	diclofenac sodium, ibuprofen, naproxen (except naproxen CR or naproxen suspension)	
Pain, Migraine CGRP Inhibitors	AIMOVIG	AJOVY, EMGALITY	
Pain and Inflammation, Nonsteroidal Anti- inflammatory Drugs (NSAIDs) / Combinations	CapsFenac Pak, Capsinac, Diclofex DC, DicloHeal-60, Iclofenac CP, Kapzin DC, Pennsaicin, Sure Result DSS Premium Pack, Ziclopro*	diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution, ibuprofen, meloxicam tablet, naproxen (except naproxen CR or naproxen suspension)	
Pseudobulbar Affect	NUEDEXTA*	Consult Doctor	

\* Changes effective 04/01/2022.

**DENTAL BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

**Dentist and Dental surgeon Services Covered under Medical Services - Clarification – Fall 2015**

MCTWF medical benefits cover 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. Charges first are applied against available dental benefit limits before being covered under the member's medical benefits.

**Dental Occlusal Guard Benefit Limitations (Winter 2019 – 2020)**

An occlusal guard is a removable dental appliance that is designed to minimize the effects of bruxism (grinding) and other occlusal factors. Occlusal guards, adjustments and relines are covered under the MCTWF Actives Plan and MCTWF Retirees Plan Supplemental Benefits Rider dental benefit as Class II basic restorative services, and apply toward your annual dental benefit maximum and, if applicable, toward your dental benefit deductible (see your benefit package's Schedule of Benefits).

- Dental occlusal guard benefit limitations under any dental benefit option are as follows:
- Occlusal Guard: Payable once per lifetime.
- Occlusal Guard Complete Adjustment: Payable once per sixty-month period.
- Occlusal Guard Limited Adjustment: Payable not more than three times in a sixty-month period.
- Occlusal Guard Reline: Payable once per thirty-six-month period

**Dental Preventive Services (Winter 2019 – 2020)**

Members with high-risk medical conditions:

MCTWF dental benefits include expanded preventive services (four teeth cleanings and two fluoride applications per calendar year in part) for covered individuals with certain high-risk medical conditions. Please refer to the Summary Plan Description booklet (SPD) for the list of illnesses considered high risk medical conditions.

For those individuals, regardless of age, undergoing head and neck radiation treatment, this benefit includes all additional covered dental services deemed necessary to minimize the destructive impact of the radiation therapy, despite MCTWF's time or frequency limitations. This includes x-rays necessary to assess the patient's dental conditions. Supporting documentation must be submitted to MCTWF's Utilization Review Department for coverage of these services.

Members without high-risk medical conditions:

All members with MCTWF dental benefits who are not considered as a high-risk medical patient are limited to the standard two cleanings per year and fluoride applications are limited to twice per calendar year for dependent children up to 14 years of age. For information on periodontal cleanings, see page 9.

**Periodontal Maintenance Coverage (Winter 2019 – 2020)**

Following a periodontal service, dental cleanings (prophylaxes) are extended to below the gums to clean into those deeper pockets under the gum line where there is bone loss. Such cleanings are referred to as periodontal maintenance and replace routine cleanings.

Effective January 1, 2020, the calendar year limit of two dental cleanings includes routine prophylaxis services and periodontalmaintenance services. Whether alone or in combination, coverage is limited to two such services per calendar year

**Dental Benefit Exclusion: Non-Intravenous Conscious Sedation (Fall 2021)**

Non-intravenous conscious sedation is intended to make dental treatment less stressful for the patient. It has gained popularity by those who may be uncomfortable visiting the dentist for various reasons or can't cope with spending extended periods of time in the dentist's chair. This type of sedation, if not medically necessary, is a personal choice and the patient will be charged for this service. It is not covered by your MCTWF dental benefits.

The "Dental Expenses Not Covered" in the MCTWF Actives Plan MCTWF Retirees Plan Summary Plan Description Booklet has been updated to the following:

"General anesthesia, intravenous sedation and/or non-intravenous conscious sedation for restorative dentistry, or for surgical procedures, unless Medically Necessary, is not a covered benefit."

**VISION BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

**MCTWF'S New Vision Program – EyeMed Vision Care (Fall 2016)**

We are pleased to formally announce that effective October 1, 2016, EyeMed Vision Care is MCTWF's new vision benefits administrator. MCTWF has contracted with it for access to its broad Insight Network. You have received notifications from MCTWF and from EyeMed in September with updated MCTWF Networks cards and EyeMed ID cards and a list of Insight Network participating retail and independent eyewear providers situated closest to your home (you can view a comprehensive list of EyeMed Insight Network providers by linking to them on the Provider Networks page of the Fund's website at [www.mctwf.org](http://www.mctwf.org)). EyeMed's Insight Network offers MCTWF participants and beneficiaries who have vision benefits a far larger number of optometrists and ophthalmologists and retail eyewear locations, faster lens crafting time, and equal or better vision benefits, options, and discounts than they had previously. Network retailers include SVS Vision (Teamster represented), Lenscrafters, Pearle Vision, Target Optical, Sears Optical, and JCPenney. Please note that if you already have used up your vision benefits (exam, lenses and/or frame, or contacts) for calendar year 2016, you will not be entitled to new vision benefits until January 1, 2017. However, in any year that you've exhausted your vision benefits, EyeMed Insight Network providers will discount their normal retail charges by 40% on each pair of complete prescription eyeglasses.

EyeMed also offers on-line eyeglass options through [www.glasses.com](http://www.glasses.com) (you also can download the glasses.com app, which uses digital try-on technology to create a 3D model of your face, to see how thousands of styles look on you from any angle) and on-line contact lens options through [www.contactsdirect.com](http://www.contactsdirect.com).

To access either site, click on EyeMed on the Provider Networks page of the Fund's website and then locate them at the top of the Provider Search Results page (you also will find [www.eyemedlasik.com](http://www.eyemedlasik.com) there for in-network laser vision correction providers). Both sites price their products in accordance with the MCTWF vision benefit and provide free shipping

**Michigan Conference of Teamsters Welfare Fund**

<b>VISION BENEFITS</b>	<b>EYEMED INSIGHT NETWORK COVERAGE</b>	<b>NON-NETWORK COVERAGE</b>
<b>EXAMINATION with Dilation as Necessary</b>	Covered in full	Up to \$50
<b>RETINAL IMAGING</b>	Up to \$39 copay	No coverage
<b>CONTACT LENS EXAMINATION OPTIONS</b> Standard Contact Lens Fit and Follow-Up Premium Contact Lens Fit and Follow-Up	Up to \$40 copay No coverage. Member receives 10% discount off retail price.	No coverage
<b>FRAMES</b> (Any Available Frame at Provider Location)	Covered up to \$125, 20% discount off balance over \$125	Up to \$75
<b>STANDARD PLASTIC LENSES - Per Pair</b> Single Bifocal Trifocal and Lenticular Standard Progressive Lens Premium Progressive Lens Tier 1 Premium Progressive Lens Tier 2 Premium Progressive Lens Tier 3 Premium Progressive Lens Tier 4	Covered in full Covered in full Covered in full \$42 copay \$72 copay \$82 copay \$107 copay \$42 copay, then 20% discount off retail price less \$120 allowance	Up to \$50 Up to \$60 Up to \$70 Up to \$70
<b>LENS OPTIONS - Per Pair</b> UV Treatment Tint (Solid or Gradient) Standard Plastic Scratch Coating Standard Polycarbonate - Adults Standard Polycarbonate - Kids under 19 Standard Anti-Reflective Coating Premium Anti-Reflective Coating Tier 1 Premium Anti-Reflective Coating Tier 2 Premium Anti-Reflective Coating Tier 3  Polarized Photochromatic / Transitions Plastic High Index Other Lens Options	\$15 copay \$15 copay Covered in Full \$35 copay Covered in Full \$40 copay \$55 copay \$68 copay No coverage. Member receives 20% discount off retail price. \$75 copay \$70 copay \$60 copay No coverage. Member receives 20% discount off retail price.	No coverage
<b>CONTACT LENSES - Materials Only</b> Conventional Disposable  Contacts Direct Benefit Booster	Covered up to \$120, 15% discount off balance over \$120 Covered up to \$120  \$20 additional contact lens allowance when lenses purchased through contactdirect.com	Up to \$80 Up to \$80  No Coverage
<b>LASER VISION CORRECTION - Per Eye</b> (Lasik or PRK from U.S. Laser Network)	Member receives 15% discount off retail price or 5% off promotional price less \$250 allowance per eye per lifetime.	Up to \$250 per eye per lifetime
<b>ADDITIONAL BENEFIT</b>	Members receive a 40% discount off complete pair eyeglass purchases once the funded benefit has been used.	No coverage
<b>FREQUENCY:</b> Examination, Lenses or Contact Lenses and Frame	One exam and one vision correction option per person per calendar year. A vision correction option is defined as 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.	

Note: If you utilize an ophthalmologist 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 EyeMed Insight network. If you are being treated by an ophthalmologist for a medical condition, services will be covered under the medical portion of your benefit package. To receive network-level benefits, the ophthalmologist must participate in the BCBS PPO network.

By clicking on EyeMed on the Provider Networks page of the Fund's website and registering through the Member Login, you can view your vision benefits, claims, special vision offers, provider locations and wellness information.

EyeMed also has arranged for discounted hearing aids and services through Amplifon (locations are nationwide), for those who are eligible for MCTWF medical and vision benefits. To find a hearing care provider near you and schedule a hearing exam, call 844- 526 5432. These hearing benefits are covered under your medical program, so please present your Blue Cross ID card to the provider for proper claim submission.

#### **EyeMed Vision Improvement Benefit (Winter 2019 – 2020)**

The MCTWF Actives Plan and MCTWF Retirees Plan Supplemental Benefits Rider frame allowance, when utilizing an EyeMed® network provider has been increased by MCTWF's Trustees to \$150 plus a 20% discount off the balance over \$150. MCTWF's frame allowance for out-of-network purchases is unchanged at \$75.

EyeMed's Enhanced Provider Search has more than 100,000 network providers to choose from. You can filter a search to find providers nearby that have the frame brands, hours, and services you want most. Browse on your PC or download the EyeMed Members App through the Apple App Store or Google Play. For more information on EyeMed Services, visit [www.eyemed.com](http://www.eyemed.com) or link to it through our website at [www.mctwf.org](http://www.mctwf.org), under the Info Links tab.

### **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – MCTWF ACTIVES PLAN**

#### **Death and Accidental Death & Dismemberment Benefits Payable to Minors (Fall 2016)**

Effective August 4, 2016, if the named beneficiary of Death or Accidental Death and Dismemberment benefits is under 18 years of age at the time the claim accrues, the beneficiary's claim filing deadline is the greater of 12 months following his/her 18th birthday, or the remaining time under the MCTWF Actives Plan general death benefit claim filing deadline of 36 months from the date of death.

#### **Death and Accidental Death & Dismemberment Benefits Payable to Minors (Fall 2016)**

Effective August 4, 2016, if the named beneficiary of Death or Accidental Death and Dismemberment benefits is under 18 years of age at the time the claim accrues, the beneficiary's claim filing deadline is the greater of 12 months following his/her 18th birthday, or the remaining time under the MCTWF Actives Plan general death benefit claim filing deadline of 36 months from the date of death.

#### **Designating and Updating Your Death Benefit Beneficiaries (Spring 2017)**

MCTWF's Summary Plan Description states that death benefits will be paid to the named beneficiary most recently listed on your Enrollment Card (or for Retiree death benefits, the Death Benefit Program Election Form) or Change of Beneficiary Form and that regardless of your subsequent divorce, if your last-named beneficiary was your spouse at the time of designation, your death benefits will be paid to that person if he or she claims the benefit. This is true no matter what is ordered in your judgment of divorce or provided for under State law. As an employee welfare benefit plan, MCTWF is governed by ERISA, a federal law that preempts State law in this regard and so the Summary Plan Description rules prevail.

## DEATH BENEFITS – MCTWF ACTIVES PLAN

### **Survivor Health Benefits – Clarification –(Fall 2015)**

MCTWF's Survivor Health Benefits, which was announced in the fall 2014 issue of the *Messenger*, provides up to 36 months (subject to ongoing eligibility rules) of free medical and prescription drug coverage for all eligible spouses and dependent children of participants who die while actively covered under a MCTWF benefits package covering such benefits (through active employment, MCTWF strike coverage, MCTWF benefit bank coverage, or weekly accident and sickness benefit coverage). However, if at the time of death the deceased participant's employer has ceased to maintain MCTWF benefits for the deceased participant's employee unit, his survivors will not be eligible for Survivor Health Benefits.

Therefore, please keep your death benefit beneficiary designation up to date. To add or change beneficiaries from those on your enrollment card, go to the *Forms* page of MCTWF's website at [www.mctwf.org](http://www.mctwf.org) and fill out the Change of Beneficiary form and return it to MCTWF.

## HOW TO FILE A CLAIM – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

### **Time Limits for Receipt of Claim Submissions - Reminder (Spring 2017)**

The following is a list of claim types and current corresponding time limits for receipt:

- Claims for health, dental, and vision benefits must be received by MCTWF within 15 months following the date that the eligible expense is incurred (i.e., the date the services were rendered).
- Claims for weekly accident and sickness benefits and total and permanent disability benefits must be received within 15 months following the date that the disability is incurred (which, for this purpose, is the date of first medical service to treat the disability).
- In either case, if such timely claim is incomplete, or additional information is required to adjudicate the claim, you will be given 45 days from the date of MCTWF's request to provide the necessary additional information, regardless of the exhaustion of the 15-month time limit. If you fail to provide the requested information within the 45-day period resulting in the denial of the claim, subsequent provision of the requested information will be considered on an appeal basis only and must be received within the 180 day from the notification of the claim denial.
- Claims for participant death benefits and accidental death and dismemberment benefits must be received within three years following the date of death or dismemberment. If the named beneficiary is under 18 years of age at the time the death occurs, the beneficiary's claim must be received before the later of one year following his/her 18th birthday, or three years from the date of death.
- Claims for spouse and dependent child death benefits must be received within three years after the date of death.

### **Reimbursement for Out-of-Network Claims (Winter 2019 – 2020)**

MCTWF receives numerous requests from members for benefit reimbursement without a completed claim form. The Summary Plan Description states that to receive reimbursement for those services, you are obligated to submit the paid receipt to MCTWF along with a completed claim form within 15 months of the date of service. Claim forms are available at [www.mctwf.org](http://www.mctwf.org) or by contacting MCTWF's Member Services Call Center at 800-572-7687.

## ASSIGNMENT, SUBROGATION AND REIMBURSEMENT – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

### **Work Related Injury/Illness – New Conditional Coverage (Fall 2015)**

Under MCTWF's General Exclusions and Limitations listed in your Summary Plan Description it states in part that an 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 is not covered.

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However, effective August 6, 2015, once the injured party has permanently settled his claim with the responsible party by way of a “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 MCTWF 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 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 MCTWF benefit package.

### **Third Party Liability Questionnaires (Spring 2016)**

The Fund has subrogation rights that allow it to recover against third parties the value of benefits paid by it on behalf of participants and beneficiaries in connection with injuries or illnesses incurred on-the-job, or in connection with a motor vehicle, or caused in whole or in part by other third parties. Claims are reviewed post-payment to determine whether there may be third party liability and, if so, a questionnaire is sent to the individual, inquiring how the injury or illness was sustained. This data gathering process is now handled for the Fund by Blue Cross Blue Shield of Michigan.

### **Recovery of Erroneous Benefit Payments (Winter 2020 – 2021)**

As stated in MCTWF’s Summary Plan Description booklet, 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. MCTWF has the right and obligation to recover such erroneous payments from: • any person to whom the payments were made; • any person for whom the payments were made, • any insurance company or organization to which the payments were made, and • directly from the participant or beneficiaries. The participant and/or beneficiaries are required to provide the Fund with any instructions and papers that may be necessary to recover erroneous benefit payments (also referred to as “overpayments.”) MCTWF also has the right to recover overpayments by deducting the overpayment amount from any future benefits. Upon discovery of an erroneous benefit payment, an offset will be made to any MCTWF Actives Plan (including COBRA Continuation Coverage) or MCTWF Retirees Plan benefits to which the participant or beneficiary is otherwise entitled (including, but not limited to, weekly accident and sickness, total and permanent disability, death, and accidental death and dismemberment benefits) to satisfy the outstanding overpayment. Furthermore, eligibility to participate in any Fund self-contributory program, including retirees medical or retiree death benefits, will be immediately suspended. If in the process of pursuing an overpayment, following issuance of a final demand letter by MCTWF, repayment of the full amount owed must be made within 21 days or a written repayment agreement must be entered into with MCTWF or all remaining benefit entitlement, including but not limited to medical, extended disability, prescription drug, dental, and vision, will be immediately suspended until such time as the overpayment is fully repaid. Once the overpayment is fully repaid, coverage will be retroactively reinstated.

If you receive such a questionnaire, it is important that you answer it completely and return it in the self-addressed, postage-paid envelope. Your failure to do so may result in the denial of future related claims and pursuit of recovery of those already paid.

## **COORDINATION OF BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

### **Coordination of Benefits (COB) Rules for Employee, Spouse, and Retiree Coverage - Clarification (Fall 2015)**

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

A group benefit plan that does not have a Coordination of Benefits (COB) provision is always primary to MCTWF. If all benefit plans have a COB provision, under MCTWF rules, the primary plan is determined as follows:

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

**Other Group Health Insurance Coverage (Spring 2016)**

Health insurance plans, including the MCTWF Actives Plan and the MCTWF Retirees Plan, follow “coordination of benefits” rules for determining primary and secondary responsibility for the payment of claims when two or more plans are responsible for payment of the same claim. Accordingly, every health insurance plan seeks to maintain current information, through periodic inquiries, to ascertain whether its participants (or insureds) are covered by other health insurance. Since Blue Cross Blue Shield of Michigan has ceased making such inquiries of you on the Fund’s behalf, we must do so.

The Fund has commenced annual issuance to participants of a Coordination of Benefits Information form asking whether participants, spouses, or children are covered under other group health insurance. The forms will be mailed out throughout this year and then every twelve months to you thereafter. Please supply the requested information and mail or fax the form back to the Fund as soon as possible so that your claims can be properly adjudicated.

**Coordination of Benefits for Medical Services – Rule Modification (Winter 2017-2018)**

Effective July 1, 2018, Part 17 of MCTWF’s SPD booklet is amended, in part, as follows: If the Fund is the Secondary Plan it will subtract the Primary Plan’s payment from the Primary Plan’s Allowed Amount (resulting in a “net allowed amount”) and, subject to the MCTWF Actives Plan or MCTWF Retirees Plan benefit package’s Deductible, Copayment and Coinsurance amounts, will pay the net allowed amount in a sum not to exceed the MCTWF Actives Plan’s or MCTWF Retirees Plan’s Allowed Amount.

**Coordination of Benefits (COB) – MCTWF Actives Plan and Medicare (Winter 2020 – 2021)**

An individual who is eligible for coverage under the MCTWF Actives Plan or MCTWF Retirees Plan benefits may also be eligible for coverage under another group health plan (“other coverage”). The process by which the plans determine between themselves primary and secondary responsibility for coverage is known as coordination of benefits (or COB). This article addresses the MCTWF Actives Plan COB rules when that other coverage is Medicare. It is very important that MCTWF be immediately notified when you or a family member becomes eligible for Medicare by sending to MCTWF a copy of the Medicare card or letter from the Social Security Administration stating the effective date of the Medicare coverage. MCTWF Actives Plan – COB with Medicare For Active Participants • If you are employed by a contributing employer and you or your spouse or child are eligible for Medicare Part A due to age (65 or older) or disability, the MCTWF Actives Plan is primary to Medicare. • If you or your spouse or eligible child is covered by Medicare due to ESRD (end-stage renal disease), the MCTWF Actives Plan is the primary plan for up to 30 months from the Medicare eligibility date. After the 30-month period, Medicare becomes the primary plan and, as the secondary plan, the MCTWF Actives Plan is responsible, up to its benefit package limits, for claims expense not covered by Medicare Part A and Medicare Part B benefits. If, in such case, you or your eligible beneficiary are not enrolled in Medicare Part B, under MCTWF Actives Plan COB rules, the MCTWF Actives Plan will determine its benefit responsibility as if you or your eligible beneficiary were enrolled in Medicare Part B.

\* For COBRA Beneficiaries • If you or your eligible beneficiary 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 and, as the secondary plan, the MCTWF Actives Plan is responsible, up to its benefit package limits, for claims expense not covered by Medicare Part A and Medicare Part B benefits. If, in such case, you or your eligible beneficiary are not enrolled in Medicare Part B, under MCTWF Actives Plan COB rules, the MCTWF Actives Plan will determine its benefit responsibility as if you or your eligible beneficiary were enrolled in Medicare Part B.\* • If you or your spouse or eligible child is covered by Medicare due to ESRD (end-stage renal disease) 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 becomes the primary plan, and, as the secondary plan, the MCTWF Actives Plan is responsible, up to its benefit package limits, for claims expense not covered by Medicare Part A and Medicare Part B benefits. If, in such case, you or your eligible beneficiary are not enrolled in Medicare Part B, under MCTWF Actives Plan COB rules, the MCTWF Actives Plan will determine its benefit responsibility as if you or your eligible beneficiary were enrolled in Medicare Part B.\* \*If the member only enrolled in Medicare Part A, and did not enroll in Part B, Part B claims will be considered as having been paid by Medicare, as primary, at 80% of the allowable amount.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN**

**HIPAA Notice of Privacy Practices (Fall 2016)**

HIPAA regulations require the triennial publication of a Plan's HIPAA Notice of Privacy Practices. The following is MCTWF's HIPAA Notice of Privacy Practices, last amended November 2016. It also can be found on the HIPAA Privacy Rule page of MCTWF's website at [www.mctwf.org](http://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** (see below for more information on these rights and how to exercise them) 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** (see below for more information on these choices and how to exercise them) 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

**(Please note that this Notice uses HHS prescribed model language, but MCTWF does not market or sell medical information, or use it for any purpose other than to administer its benefit plans.)**

**Our Uses and Disclosures** (see below for more information on these 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

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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 8.
- 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/](http://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.

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. (note: MCTWF does not market information.)
- Sale of your information. (note: MCTWF does not sell 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. (**note: MCTWF's Board of Trustees is your plan sponsor.**)

#### **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](http://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 action**

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 your 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](http://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 November

2016 Privacy Officer: Barbara

McGuire (313) 964-2400 ext. 202

privacyofficer@mctwf.org