



SUMMARY PLAN DESCRIPTION BOOKLET



Michigan Conference of Teamsters Welfare Fund

MCTWF Actives Plan
MCTWF Retirees Plan

April 2022



IMPORTANT – PLEASE NOTE

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

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

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

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IMPORTANT PHONE NUMBERS-MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

For verification of eligibility, benefits or to determine the status of a claim, please call the Fund's Member Services Call Center-

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

For participating provider referrals, after hours, please call -

Blue Cross Blue Shield of Michigan (800) 810-2583
Delta Dental of Michigan (800) 524-0149

For prescription drug matters please call -

CVS/Caremark Mail Service and Retail Pharmacy (888) 727-0495
CVS/Caremark Specialty Pharmacy Services.....(800) 237-2767 PrudentRx.....(800) 578-4403

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

CVS /Caremark (800) 626-3046

For prior authorization of non-emergent outpatient CT Scans, Echocardiography Services, MRIs, PET Scans, In-Lab Sleep Studies and Nuclear Cardiology, providers in Michigan must call BCBSM. For prior authorization of non-emergent outpatient CT Scans, Echocardiography Services, MRIs, PET Scans, In-Lab Sleep Studies and Nuclear Cardiology Non-BCBSM and Non-Michigan providers must call the Fund's Utilization Review Department -

Blue Cross Blue Shield of Michigan - American Imaging Management(800) 728-8008
The Fund's Utilization Review Department..... (800) 572-7687 ext. 478

For prior authorization of Skilled Nursing Facility care, providers in Michigan must call BCBSM. Non-BCBSM and Non-Michigan providers must call the Fund's Utilization Review Department

Blue Cross Blue Shield of Michigan (800) 482-4040
The Fund's Utilization Review Department..... (800) 572-7687 ext. 478

For prior authorization of Bariatric Surgery, Blepharoplasty & Ptosis Repair - Upper Lid, Breast Reduction or Reconstruction, Durable Medical Equipment Purchase, Growth Hormone Stimulation, Home Health Care, Hospice Care and Gastric Electrical Stimulation Therapy, providers must call the Fund's Utilization Review Department -

The Fund's Utilization Review Department..... (800) 572-7687 ext. 478

For prior authorization of Human Organ Transplant Procedures, providers in Michigan call BCBSM. Non-BCBSM and Non-Michigan providers must the Fund's Utilization Review Department.

Blue Cross Blue Shield of Michigan(800) 242-3504
The Fund's Utilization Review Department..... (800) 572-7687 ext. 478

For prior authorization of inpatient Mental Health and Substance Use Disorder treatment, providers must call -

Blue Cross Blue Shield of Michigan(800) 762-2382

For Applied Behavioral Analysis, must call -

Blue Cross Blue Shield of Michigan(877) 563-9347

For Medical, Dental Optical and Hospital claims fraud matters, please call -

For Dental claims - call Delta Dental of Michigan(800) 524-0147
For Hospital claims - call Blue Cross Blue Shield of Michigan.....(800) 482-3787
For Optical Claims - call EyeMed(866) 939-3633

INTRODUCTION

MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

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

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

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

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

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

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

The Trustees have the right to modify, revoke, suspend, terminate or change these benefits and/or provisions, in whole or in part, at any time without prior notice. If the MCTWF Actives Plan or MCTWF Retirees Plan is terminated, the Trustees may use its remaining assets, after paying claims, to pay its remaining expenses, or may contribute those remaining assets to a new welfare benefit plan established through collective bargaining.

The Fund will terminate your coverage if the Trustees, in their sole discretion, determine that You, or your legal representative, knowingly provide false information, directly or indirectly, with the intent to cause the MCTWF Actives Plan or MCTWF Retirees Plan to provide coverage, benefits, or payments that You or a third party is not entitled to receive. Any act, practice, or omission by an individual that constitutes fraud or an intentional misrepresentation of material fact to MCTWF Actives Plan or MCTWF Retirees Plan is prohibited and the Trustees may terminate your benefit eligibility as a result. Failure to provide timely notice to your MCTWF Actives Plan and MCTWF Retirees Plan of a change in status, including, but not limited to, a change in status resulting from divorce, a change in your employment status (i.e., layoff, termination, quit, sick, personal leave, retirement, military leave, etc.) or eligibility for Medicare, is an intentional misrepresentation of material fact.

No document, including financial instruments such as checks or money orders, shall be presumed to have been received by the Fund unless actually received, regardless of the circumstances of mailing.

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The following are not covered under the MCTWF Actives Plan and MCTWF Retirees Plan:

Accidental injury or illness arising in the course of employment are not Covered under the MCTWF Actives Plan and MCTWF Retirees Plan:

- expenses incurred for care of injuries or illnesses due to war or war-related acts;
- any expenses You incur that You are not legally required to pay;
- 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 went into effect July 2, 2020. Under the Reform law, Michigan drivers will be able to choose lower levels of personal injury protection (PIP) 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.
- in such cases where other medical coverage is available, no MCTWF Actives Plan or MCTWF Retirees Plan benefits will be paid for automobile-related Accidental Injury or Illness on your behalf if You are the operator or occupant of a rental vehicle;
- any surgery or medical care or service furnished by any facility contracted for or operated by the United States Government or by any other governmental unit for medical care or treatment unless a charge is made that You are legally required to pay;
- charges for completing claim forms or missed appointments;
- claims made for benefits beyond fifteen months from the date the expense was incurred (i.e., the date services were rendered);
- Accidental Injury or Illness suffered while in the armed forces of the United States;
- in such case where a MCTWF Retirees Plan Participant and/or his Spouse, or a COBRA Beneficiary becomes eligible for Medicare coverage, no MCTWF Retirees Plan benefits will be paid; and
- repair or replacement made necessary because of loss or damage due to misuse, mistreatment or theft.

SEC. 2.1: ELIGIBILITY MCTWF ACTIVES PLAN and MCTWF Retirees Plan

2.1(a) ENROLLING IN THE PLAN

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

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

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

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

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

You must provide all required documentation concerning yourself and all of your eligible beneficiaries to permit initial enrollment.

2.1(b) UPDATING ENROLLMENT INFORMATION

Family Status Changes

The time frame to request special enrollment is extended during the pandemic (outbreak period). The extension is available from the period of March 1, 2020 until 60 days after the end of the National emergency. (For all COVID-19 related information, see Section 21).

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

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

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

If You fail to notify the Fund of a family status change, as required above, 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 in full.

Participant Information Changes

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

Untimely Reporting of Employee Status Changes

The Fund requires that all contributing employers timely report all active employment status changes (i.e., layoffs, terminations, resignations, retirements, 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.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is a court order providing for child support, usually resulting from a divorce or legal separation that -

- designates one parent to pay for a child's health Plan coverage;
- indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
- states the period for which the QMCSO applies; and
- identifies each health care Plan to which the QMCSO applies.

If a court has issued an order with respect to health care coverage for any of your Dependent children, the Fund will determine if the court order is a QMCSO as defined by federal law.

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

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

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

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

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

2.1(c) ELIGIBILITY FOR COVERAGE

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

Eligibility for Coverage Based on Weekly Contributions

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

If You are on layoff the day your benefits would normally become effective and You return to active employment, your coverage will begin upon your return. However, if your eligibility for coverage ceases as a result of layoff, eligibility will be reinstated upon resumption of active Covered employment.

If You are retired and Covered under an Active benefit plan, benefit eligibility for You or your spouse (if applicable) ceases as of the earlier of (a) the first of the month in which You or your spouse attains age 65, or (b) the date You or your spouse becomes eligible for early Medicare A coverage.

You are Covered for benefits under an MCTWF Actives Plan only for weeks for which your Employer has made Contributions to the Fund on your behalf, except as You may be entitled to extended coverage through application of benefit bank weeks (see Sec. 2.1(h), Benefit Bank Weeks) or due to a non-work related Disability (see Sec. 4.2, Continuation of Benefit Eligibility) or due to your COBRA continuation coverage participation (Sec. 2.2, COBRA Continuation Coverage). You must have a contribution reported for the week services are received to be eligible for benefits.

Eligibility for Coverage Based on Hourly/Daily Contributions

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

Furthermore –

- If You are currently eligible for MCTWF Actives Plan benefits based upon weekly Contributions made (and benefit bank weeks applied) on your behalf, the Fund will convert weekly Contributions made (and benefit bank weeks applied) for the two calendar months prior to the effective date of the change to hourly or daily Contributions to create immediate eligibility. Remaining benefit bank weeks will be available to You only upon future reestablishment of participation pursuant to weekly Contributions.
- If You are not currently eligible for MCTWF Actives Plan benefits, coverage will begin on the

first day of the second month following the month in which the minimum number of required hours or Days is contributed by the Employer. The minimum number of hours or Days required may be established during two consecutive months if necessary.

- Once initial eligibility is established it is maintained from month to month if the minimum number of required hours or Days is contributed by the Employer. Hours or Days, i.e., those greater than the minimum number of required hours for a four week month and those greater than the minimum number of required hours or Days for a five week month, are converted to a Dollars Bank, using the then current hourly or daily contribution rate. The Dollars Bank is used to supplement succeeding months in which Employer Contributions fall below the minimum number of required hours or Days, by reconverting dollars to hours or Days using the then current hourly or daily contribution rate.
- The Dollars Bank is also used to extend eligibility (in full monthly units only), during months of non-payment by the Employer, e.g., layoff, personal leave, voluntary or involuntary terminations, etc. The Dollars Bank may not be used for any other purpose or cashed out.
- When the Dollars Bank is insufficient to establish a full month's eligibility, self-Contributions at the Employer rate may be made by You to supplement the Dollars Bank. Self Contributions must be made within 15 Days of the date of the Fund's invoice. Failure to supplement will result in loss of coverage and will freeze use of the Dollars Bank until receipt of Employer contributions.
- If the contribution shortage is not supplemented by You at the Employer contribution rate, You will be offered COBRA continuation coverage (see Sec. 2.2, COBRA Continuation Coverage).
- The Fund will issue You a monthly account statement reflecting the most recent Contributions made on your behalf, the period for which eligibility, if any, has been established, and your current Dollars Bank balance.

Eligibility for Coverage Based on Marriage

Same Sex Marriage Eligibility – Termination of Domestic Partner Eligibility

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

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.

2.1(d) COVERING YOUR BENEFICIARIES

MCTWF Actives Plan coverage is available for certain family members. They become Covered by the MCTWF Actives Plan when your eligibility for coverage begins, or if later, on the date they become Beneficiaries as defined below (for example, on the date of your marriage or child's birth, etc.). Beneficiary coverage continues until the earlier of your loss of eligibility or your Beneficiary's loss of Beneficiary status. If your Beneficiary is confined to a Hospital on the

day he or she becomes eligible for your MCTWF Actives Plan benefits, their prior health Plan remains responsible for charges in connection with that confinement.

In accordance with the Affordable Care Act, MCTWF has made coverage available to all dependent adult children.

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 is contingent upon submission to MCTWF of an *Adult Child Coverage Application for Enrollment Form*.

Dependent Eligibility for Wards of Guardians:

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.

Your Beneficiaries are -

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

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 or by contacting MCTWF's Member Services Call Center.

If your step child is Covered as a Dependent and your Spouse dies, the Fund will provide temporary, contingent coverage to that child for 60 Days. If within that time period You provide documentation of your primary custodial responsibility and primary financial support of the child, the Fund will extend the temporary coverage to that child for up to one year (including the initial 60 Days) to allow time for legal adoption or for You to obtain other

insurance for the child. If proof of adoption is not received within the one year period, coverage for the child will terminate at the end of the period.

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

2.1(e) LOSS OF ELIGIBILITY

As a general rule, You will lose eligibility for benefits under the MCTWF Actives Plan, under any of the following circumstances:

- your employment with a Contributing Employer ends;
- your Employer stops making Contributions to Michigan Conference of Teamsters Welfare Fund on your behalf;
- You stop making self-Contributions;
- your death;
- your Employer no longer participates with the Fund; or
- the Trustees of the MCTWF Actives Plan change, amend or terminate your MCTWF Plan.

Notwithstanding the general rule, your eligibility for benefits may continue if You -

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

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

2.1(f) IF YOUR EMPLOYMENT ENDS

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

Termination

If You voluntarily end your employment or are discharged and -

- your Employer contributes on a weekly basis, your coverage will end at midnight on Saturday of the last week for which your Employer last makes Contributions to the Fund on your behalf; or
- your Employer contributes on an hourly or daily basis, your coverage will end on the last day of the month for which Contributions met the minimum requirement for monthly coverage.

When your coverage ends You may be eligible to purchase COBRA continuation coverage (see Sec. 2.2, COBRA Continuation Coverage).

Layoff

If You are laid off and your Employer ceases making Contributions to the Fund on your behalf, your medical, dental, vision and prescription drug benefits will remain in effect for as long as You have remaining benefit bank weeks if your MCTWF Actives Plan provides benefit bank weeks.

When your benefit bank weeks run out, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.2, COBRA Continuation Coverage).

2.1(g) IF YOUR EMPLOYER WITHDRAWS FROM MCTWF ACTIVES PLAN PARTICIPATION

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

Eligibility for MCTWF Retirees Plan - Post Collective Bargaining Agreement Expiration

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.

2.1(h) BENEFIT BANK WEEKS

Using Your Benefit Bank Weeks

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

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

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

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

If You are not actively employed and are still covered by remaining benefit bank weeks before the date on which the defined period of benefit bank weeks availability expires, You will continue to be so covered until your benefit bank weeks are exhausted. Upon your return to Active employment and the payment of Contributions on your behalf, You will receive a new allotment as specified in your Schedule of Benefits for the new defined period.

Benefit bank weeks may be used to continue your MCTWF Actives Plan's medical, dental, vision, and prescription drug benefits, however, no weekly accident and sickness, total and permanent disability, death benefits, or accidental death and dismemberment benefits will be available to cover such services or events when incurred during benefit bank weeks.

You Are Not Eligible for Benefit Bank Weeks -

- if your MCTWF Actives Plan benefit package does not provide benefit bank week coverage; or
- if You quit.

2.1(i) STRIKE OR LOCKOUT

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

- the strike must be sanctioned by the International Brotherhood of Teamsters (IBT) or the locked out employees must be supported, as evidenced by payment of IBT strike wages;
- the Fund must receive written confirmation of strike sanctioning or support from the IBT which must include the inception and termination dates, the name of the Employer, and a list of affected Participants, along with other necessary information, from your Local Union;
- coverage will not be provided if You are on leave of absence, sick leave (until your return from leave), layoff, or have been terminated;
- your Employer must not be more than 30 Days delinquent in making required Contributions to the Fund at the commencement of the temporary work stoppage;
- your unused benefit bank weeks will be applied immediately so as to avoid a lapse in your medical, dental, optical and prescription drug benefits. After all your benefit bank weeks have been exhausted, coverage will continue during the temporary work stoppage for a maximum of eight weeks, subject to your ongoing compliance with the Local Union's requirements for strike duty. After that, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.2, COBRA Continuation Coverage). The temporary work stoppage is a COBRA qualifying event. Consequently, the COBRA coverage continuation period commences on the date of the temporary work stoppage. The number of benefit bank weeks used plus the eight weeks of extended MCTWF Actives Plan coverage during the temporary work stoppage will offset the number of weeks of COBRA continuation coverage that You will be entitled to purchase; and
- during the temporary work stoppage, non-bargaining unit employees will receive a maximum of seven weeks extended coverage contingent on the Employer's payment of advance Contributions for that period.

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

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

2.1(j) LEAVES OF ABSENCE

Family Medical Leave

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

For those Employers to whom the FMLA applies, Basic Leave Entitlement is available -

- for your own serious Illness or incapacity due to pregnancy, prenatal medical care or child birth;
- to care for your newborn child or newly adopted child; or
- to care for your seriously ill Spouse, parent or child.

For those Employers to whom the FMLA applies, Military Family Leave Entitlement is available -

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

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

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

If your Employer grants You further leave beyond the permissible FMLA period but stops making Contributions to the Fund on your behalf, and if You have available benefit bank weeks, You have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see Sec. 2.2, COBRA Continuation Coverage).

Military Leave

If You are on leave because of military service -

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

- 31 to 180 days: The employee must apply for reemployment no later than 14 days after completion of military service.
- 181 days or more: The employee must apply for reemployment no later than 90 days after completion of military service.
- Service-connected injury or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

Other Leaves

If You take any other leave of absence and your Employer stops making Contributions to the Fund on your behalf, and if You have available benefit bank weeks, You have the option of when to apply them in conjunction with your COBRA continuation coverage rights (see Sec. 2.2, COBRA Continuation Coverage).

2.1(k) ACCIDENTAL INJURY, SICKNESS OR ILLNESS

If You are unable to work due to Accidental Injury or Illness and your Employer is not obligated to make further Contributions to the Fund on your behalf, your medical, dental, vision and prescription drug benefits will remain in effect for as long as You have benefit bank weeks remaining. However, if You are receiving weekly accident and sickness benefits from your MCTWF Actives Plan benefit package, your coverage will continue for as long as that benefit is being paid (see Sec. 4.2, Continuation of Benefit Eligibility), after which remaining benefit bank weeks are applied. When your benefit bank weeks run out, You may be eligible to purchase COBRA continuation coverage (see Sec. 2.2, COBRA Continuation Coverage).

2.1(i) REINSTATEMENT OF COVERAGE

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

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

To be eligible for reinstatement -

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

If your coverage ends because You begin active military service and your period of military service is more than 30 Days but less than 181 Days, your coverage will be reinstated if You apply for reemployment with your former Contributing Employer within 14 Days after completion of the period of military service.

If, because of circumstances beyond your control, submitting an application within the 14-day period is impossible or unreasonable, the application must be submitted on the next first full calendar day when submitting the application becomes possible.

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

on your behalf.

2.1(m) ACTIVES SURVIVOR HEALTH BENEFITS

MCTWF's Survivor Health Benefits 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 and fill out the *Change of Beneficiary Form* and return it to MCTWF.

Key Definitions

With respect to this benefit rule –

- “Survivor(s)” refers to the spouse and dependent children of the deceased participant who were eligible for MCTWF Actives Plan benefits on the date of the participant's death. Spouse and/or dependents approved for opt out and spouse and/or dependents enrolled in the Flex Dependent Coverage are not entitled to the Survivor Health Benefits coverage.
- “Survivor Health Benefits” refers to the same base medical and prescription drug benefits that the deceased participant's MCTWF Actives Plan participating group is covered for during the period of the survivors' Survivor Health Benefits eligibility.
- “Active Coverage” refers to the participant's eligibility for MCTWF Actives Plan base medical and prescription drug benefits while;
 - actively employed;
 - utilizing the Fund's strike benefits;
 - utilizing benefit banks; or
 - utilizing Weekly Accident and Sickness benefit.

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 expiration of her Survivor Health Benefits coverage, but must comply with the Fund's rules for timely application for MCTWF Retirees Plan coverage); or
 - Medicare eligibility.
- For each surviving child, for the earlier of 36 months or –
 - the end of the month in which the child turns age 26; or

- the date of the child's adoption by anyone other than the surviving spouse.
- 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.

Benefit Design

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

Coordination of Benefits

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

2.1(n) FLEXIBLE DEPENDENT COVERAGE PROGRAM

The Flexible Dependent Coverage Program (Program) provides an account for reimbursement, up to the account limit, of medical, dental and optical expenses that are not reimbursable by MCTWF or by another group health plan and that are deductible from an individual tax return, if itemized (pursuant to section 213(d) of the Internal Revenue Code). To take advantage of this Program, a participant must have composite rate contributions paid on his behalf and must agree to waive all MCTWF medical and prescription drug coverage for his spouse and dependent children. Evidence is required that the spouse and dependent children have other group health coverage.

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

- You must have Beneficiaries unless You enrolled in the Program by December 31, 2006 and remained continuously enrolled and eligible in the Program thereafter ("grandfathered") by virtue of the payment on your behalf of composite rate Contributions by your Employer;
- all of your Beneficiaries must have coverage under another group health plan, and You must provide proof to the Fund of the other coverage; and
- You must complete and submit the Fund's *Flexible Dependent Coverage Program Election Form*.

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

How to Enroll

You must enroll in accordance with the rules that follow:

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

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

Change in Family Status

You must notify the Fund immediately upon a change in family status to ensure proper handling of your claims if -

- You add a Beneficiary as a result of marriage, birth or adoption and that Beneficiary is not covered under another group health plan, your participation will cease in the Flexible Dependent Coverage Program; or
- your Beneficiaries were covered under another group health plan and lose that coverage, You may stop participating in Flexible Dependent Coverage Program at that time. You must provide proof of the loss of coverage.

2.1(o) Keeping Required Enrollment Information Current

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 MCTWF 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.

SEC. 2.2: COBRA CONTINUATION COVERAGE - MCTWF ACTIVES PLAN

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

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

2.2(a) COVERAGE ENTITLEMENT PERIOD

COBRA continuation coverage is available for 18 Months, 29 Months and 36 Months based on who the Beneficiary is and the nature of the qualifying event resulting in the loss of coverage under the plan. Effective April 1, 2012, Benefit Bank Weeks are applied toward new COBRA continuation entitlement periods.

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.

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.

When COBRA Continuation Coverage Continues For Up to 18 Months

18 months of COBRA continuation coverage is available for qualified beneficiaries pursuant to the following qualifying events:

- Employee’s termination of employment for reasons other than gross misconduct; or
- Employee’s reduction in employment hours.
- If a second qualifying event occurs within that period, coverage for the affected qualified beneficiary is extended to the maximum entitlement period permitted for such event.

When COBRA Continuation Coverage Continues For Up to 24 Months

Twenty-four (24) Months of COBRA continuation coverage is available for qualified Beneficiary (employees) on uniformed service leave and any of their dependents who were covered under the Plan at the commencement of the of the employee’s leave. If a second qualifying event occurs within that period, coverage for the affected qualified beneficiary is extended to the maximum entitlement period permitted for such an event.

When COBRA Continuation Coverage Continues For Up to 29 Months

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

If You already have COBRA continuation coverage for a period greater than 29 months, no additional extension will be granted because of Disability.

You must notify the Fund of the determination of Disability by the Social Security Administration within 60 Days after the determination.

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

If the qualifying event is a loss of coverage due to a temporary layoff, MCTWF Actives Plan continuation coverage provides additional coverage beyond COBRA continuation coverage for a maximum of 12 months beyond the COBRA entitlement period for You depending upon the length of your seniority recall period as stated in your Collective Bargaining Agreement. The combination of the COBRA continuation coverage period based on a temporary layoff and the MCTWF continuation coverage period cannot exceed the duration of the recall period. Thus, if the recall period is 24 months and You have exhausted your 18 month COBRA continuation coverage You may purchase MCTWF continuation coverage (the same COBRA package at the then current COBRA rate) for up to six months. If, however, the recall period is less than 18 months (or less than 29 months if COBRA continuation coverage was extended due to Disability), then no MCTWF continuation coverage will be available.

Furthermore, MCTWF continuation coverage will be made available only so long as You are able to enforce your seniority recall rights and your Employer remains obligated to contribute to MCTWF. Thus, if your Employer has bargained out of MCTWF, or has ceased covered operations, or no Collective Bargaining Agreement is in effect, or You are permanently disabled, MCTWF continuation coverage will not be offered, or if already commenced, will be curtailed upon notice to You of coverage cessation effective the end of the month following the month in which MCTWF so notifies You.

When COBRA Continuation Coverage Continues For Up to 36 Months

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

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

2.2(b) HOW TO ELECT COBRA CONTINUATION COVERAGE

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

Upon the Fund's receipt of the *Continuation Coverage Election Form*, a COBRA Invoice will be sent to You and You have 45 Days from the date of the invoice to make the COBRA payment. Once payment has been made, the COBRA election cannot be changed for any reason (except when adding a new Beneficiary due to marriage, newborn child, or newly adopted child, or otherwise adding a new Beneficiary).

If after You elect COBRA and before initial payment is made and within the COBRA election period, You decide to change your benefit Plan selection. You will be allowed to do this by completing a new *COBRA Continuation Coverage Election Form*. If, after You elect COBRA and before initial payment is made and within the COBRA election period, You decide to change the coverage tier (e.g. from family coverage to a named Beneficiary single coverage), this will be allowed on a prospective basis only, based on the date the new election is received and You will be responsible for the COBRA payment under the initial coverage tier retrospectively and the new coverage tier going forward. COBRA continuation coverage will commence once the Fund has received the *COBRA Continuation Coverage Election Form* and upon timely receipt of COBRA continuation coverage self-Contributions. The initial Contribution covers the period between the date of your loss of coverage to the date of your election plus any regularly scheduled monthly Contributions due between your election and the end of the 45-day period. After payment of the initial Contribution, payments are due in advance for each month on the last day of the preceding month.

Medicare Enrolled Individuals Electing COBRA Continuation Coverage

Under Federal law, if You are enrolled in Medicare and are age 65 or more, or are enrolled in Medicare based on Disability, and elect COBRA continuation coverage, Medicare is the Primary Plan for coordination of benefit purposes. Your continuation coverage Plan benefits will be

limited to greater than Medicare Part A and Medicare Part B benefits, up to your continuation coverage Plan limits, regardless of whether You have enrolled in Medicare Part B.

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an eight-month special enrollment period to sign up, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, then Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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

Notifying the Fund of Beneficiary COBRA Qualifying Event

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

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

To help ensure that You do not lose coverage, the Fund recommends that You notify us as soon as possible of any events that can cause your coverage to end.

2.2(c) LOSS OF COBRA CONTINUATION COVERAGE

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

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

health Plan;

- your Employer stops participating in the Fund and your Employer provides coverage to the Employee group under another health Plan (in that event, the other health Plan will be required to offer COBRA for the remaining period of coverage). However, if You have a health problem for which You are receiving treatment, coverage for that condition will continue until that condition is covered by another Plan or You reach the time limits for COBRA continuation coverage;
- the required Contributions are not paid on time;
- your MCTWF Actives Plan is terminated;
- You become entitled to Medicare after the COBRA election; or
- your coverage has been extended to 29 months and it is determined that You are no longer disabled.

2.2(d) Revocation of Waiver of COBRA Continuation Coverage

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.

SEC. 2.3: MCTWF RETIREES PLANS

2.3(a) ELIGIBILITY FOR PARTICIPATION

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

Retired Individuals Under Age 57

- Must be age 57 or older to enroll in MCTWF's Retirees Plan (or to defer enrollment, see deferred participation), with the exception of "30-and-Out" Pensioners age 50 or older, who meet the eligibility rules for individuals age 57 or older:
 "30-and-Out" Pensioners in a Teamster Pension Plan:
 - Ages 50 to 56 – Must meet all of the eligibility rules for individuals age 57 or older and must provide proof of a "30-and-Out" pension at the time of timely application for MCTWF Retirees Plan enrollment or deferral.
 - Under Age 50 – Must meet all of the eligibility rules for individuals ages 50 to 56 with a "30-and-Out" pension, and must defer participation in the MCTWF Retirees Plan until at least age 50 or later.

Retired Individuals Age 57 or Older - Standard Eligibility Rule

- Must have participated in an eligible MCTWF Actives Plan benefit package (i.e., one that includes the retiree coverage component) and must have had Contributions made on his behalf for coverage under an MCTWF Actives Plan, at least 40 weeks in each of the five

consecutive 52 week periods immediately preceding the Retirement Date, or at least 40 weeks in seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date; except that for periods while the retired individual, as an MCTWF Actives Plan Participant, performed Seasonal Work, eligible Contributions must have been made for an average of at least 40 weeks per 52 week period for five consecutive 52 week periods immediately preceding the Retirement Date, or an average of at least 40 weeks per 52 week period for seven out of the ten consecutive 52 week periods immediately preceding the Retirement Date (the appropriate test shall be applied pro rata based on the type of work in which the retired individual, as an MCTWF Actives Plan Participant, was engaged during the measuring period).

- Must not be eligible for Medicare coverage.
- Must not be engaged in Prohibited Employment (see Part 23: Important Definitions).

Retired Individuals Age 57 or Older - Expanded Eligibility Rule

- An individual need not retire in a MCTWF Actives Plan benefit package that includes the retiree coverage component. Sufficient prior participation in a package that does include the retiree coverage component, also will trigger eligibility for MCTWF Retirees Plan benefits. Self-contribution rates for participation in the MCTWF Retirees Plan are approximately 10% higher than the rates based on the Standard Eligibility Rules.
- For individuals who retire at age 62 or greater while covered by the MCTWF Actives Plan that does not include the retiree coverage component, participation in the MCTWF Retirees Plan eligibility for the Fund is conditioned on having accrued, at any time, 20 years of participation in any MCTWF Actives Plan benefit package that includes the retiree coverage component.
- For individuals who retire at age 57 or greater while covered by an MCTWF Actives Plan benefit package that does not include the retiree coverage component, eligibility for participation in the MCTWF Retirees Plan is conditioned on having accrued a minimum of seven of the immediately prior 10 years of participation in an MCTWF Actives Plan benefit package that includes the retiree coverage component, or a minimum of 10 of the immediately prior 15 years of participation in an MCTWF Actives Plan benefit package that includes the retiree coverage component.
- Once the requirements are met, the Participant will not lose his eligibility to enroll in a the MCTWF Retirees Plan solely by delaying his Retirement Date.
- The retired individual must not be eligible for Medicare coverage.
- The retired individual must not be engaged in Prohibited Employment (see Part 23: Important Definitions).

MCTWF Retirees Plan Enrollment Expanded Eligibility Rules

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.

2.3(b) RETIREES SUPPLEMENTAL BENEFITS RIDER

The Retiree Supplemental Benefits Rider (Retiree Rider) supplements MCTWF's Retirees Plan benefit package with hearing, vision and dental benefits, at a monthly cost-based Contribution rate, and is available at the time You enroll in MCTWF's Retirees Plan. After the Retiree Rider is elected it may be dropped, following at least one year of Retiree Rider coverage, but You must notify the Fund in writing 45 days prior to the calendar month for which the Retiree Rider coverage is to terminate. For example, to drop coverage as of January 1st, the Fund must receive written notification by November 15th. Once the Retiree Rider coverage is dropped, it will not be available to You again.

2.3(c) UNIFORMED SERVICES (MILITARY LEAVE)

Uniformed Services credit may count toward satisfying MCTWF Retirees Plan enrollment requirements for required Years of service and for determining MCTWF's Retirees Plan medical benefit package self-Contribution rate.

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

- the retired individual must have entered the Uniformed Services while working for an Employer that contributed to the Fund (a "Fund Contributing Employer") on his behalf for a MCTWF Actives Plan benefit package that included the Retiree coverage component;
- the retired individual's military leave did not exceed five Years (except due to circumstances addressed in that section of USERRA entitled "Employment Rights of Persons Who Serve in the Uniformed Services"); and
- the retired individual must have applied for return to work with an MCTWF Actives Plan Contributing Employer within the following time frames:
 - within 90 Days after completed duty time of more than 180 Days; or
 - within 30 Days after completed duty time of 31 to 180 Days; or
 - within five Days after completed duty time of up to 30 Days.

2.3(d) PLAN ENROLLMENT REQUIREMENTS

- To enroll in the MCTWF Retirees Plan, the retired individual must complete and submit to the Fund an *MCTWF Retirees Plan Enrollment Application* within 90 Days immediately following the Retirement Date and, if approved, make timely payments as billed. Benefit coverage will commence effective the day following the retirement date. If the completed Application is received beyond the 90 Day window period, but within one Year of the MCTWF Retirees Plan Retirement Date (see Part 23: Important Definitions), and, if approved, and timely payment, as billed, is made, benefit coverage will commence as of the first day of the month that falls at least 90 Days after the Fund's receipt of the application.

2.3(e) SELF-CONTRIBUTION RATES

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

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

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

2.3(f) COBRA CONTINUATION COVERAGE CONTRIBUTIONS

- Age 50 or older retiring Participants may choose to make COBRA continuation coverage Contributions to add to their Years Fund service and/or age.
- Under age 50 retiring Participants may not count COBRA continuation coverage Contributions toward establishing his Retirement Date, with the exception of those with 25 or more Years of service in the Fund.

2.3(g) RESTRICTION ON PARTICIPATION

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

2.3(h) ELIGIBILITY FOR DEFERRED PARTICIPATION

Pre-Enrollment Voluntary Deferrals

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

Pre-Enrollment Automatic Deferrals

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

Post Enrollment Voluntary Deferrals

- Retired individuals may defer participation any number of times after enrollment in a MCTWF Retirees Plan benefit package, upon written request to the Fund during the open enrollment period each year from November 1st through December 10th, which will permit resumption of participation as of January 1st. However, the deferral period must be at least six months. At such time as the retired individual seeks to resume participation in a MCTWF Retirees Plan benefit package. The self-Contribution rate will be calculated based on the retired individual's age and Years of service at the time of the initial commencement of participation in the MCTWF Retirees Plan. If the deferral is for the purpose of resuming employment, there may be a period of time before eligibility is established for the new employment based coverage. Therefore, the retired individual may continue the MCTWF Retirees Plan participation by paying his monthly self-Contribution until eligibility for the new coverage is established.

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

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

Post Enrollment Automatic Deferrals

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

2.3(i) WHEN COVERAGE BEGINS

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

2.3(j) COVERAGE FOR RETIREE SPOUSES

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

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

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

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

In the event that the Retiree Spouse exhausts her right to continue participation at the self-Contribution rate, the Retiree Spouse may continue participation as an Extended Retiree Spouse at the cost-based self-Contribution rates (reviewed annually and adjusted each Plan Year by the

Trustees), until she reaches age 65 or, if earlier, she becomes eligible for Medicare.

If, on the date of the MCTWF Actives Plan Participant's death, he would have been able to satisfy the MCTWF Retirees Plan's age and Years of service participation requirements, his Spouse may enroll in the MCTWF Retirees Plan in the same manner as prescribed for a retiring individual.

2.3(k) TERMINATION OF RETIREE PLAN ELIGIBILITY

Participation will end on the first day of the following dates:

- The date the Retiree first becomes eligible for Medicare Coverage, whether or not the Retiree enrolls in Medicare coverage. However, if Retiree's Medicare eligibility is due to End Stage Renal Disease (ESRD) federal law requires that MCTWF remain Primary to Medicare for 30 months, starting with the first month the Retiree became eligible to receive Medicare. Upon expiration of the 30-month period, MCTWF Retirees Plan participation ceases.

The Retiree Spouse's participation will end on the first of the following dates:

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

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

Except as otherwise noted, all references above to "Medicare" include both early age (Disability) and normal age Medicare Part A coverage. All references above to attaining age 65 refer to the last day of the month preceding the month in which the 65th birthday falls. In such cases where age 65 has been reached, but eligibility for Medicare has not been established, eligibility for coverage will continue under MCTWF's Retirees Plan until such time as Medicare eligibility has been established. Eligibility for MCTWF Retirees Plan coverage ceases once eligibility for Medicare Part A coverage commences. This rule applies separately to the Retiree and the Retiree's Spouse. In addition to turning age 65, Medicare coverage is provided automatically following 24 months of Social Security Disability benefits and, in the case of Amyotrophic Lateral Sclerosis, the first month that Social Security Disability benefits begin. The Fund will seek recovery directly from the Retiree and the Retiree's Spouse for benefits paid as the result of their failure to provide the Fund with advance notification of Medicare eligibility.

2.3(l) TERMINATION OF RETIREES SPOUSE PARTICIPATION

The Retiree Spouse's participation will end on the first of the following dates:

- the date the Retiree Spouse first become eligible for Medicare coverage, whether or not she enrolls in Medicare coverage. However, if the Retiree Spouse's Medicare eligibility is due to

End Stage Renal Disease (ESRD), federal law requires that MCTWF's Retirees Plan coverage remains primary to Medicare for 30 months, starting with the first month the Retiree Spouse became eligible to receive Medicare. Upon expiration of the 30-month period, MCTWF Retirees Plan participation ceases;

- the date of the Retiree Spouse's death;
- the date the Retiree Spouse becomes eligible for coverage under an MCTWF Actives Plan benefit package;
- the date of the Retiree engages in Prohibited Employment;
- the date the Fund fails to receive the self-Contribution when due;
- the date the Retiree and Retiree Spouse divorce;
- the date the Retiree Spouse remarries after the Retiree's death; or
- the effective date (1) termination of MCTWF's Retirees Plan or (2) an amendment to MCTWF's Retirees Plan that causes the Retiree to be eligible for coverage.

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

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

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

2.3(m) RECOGNITION OF OTHER FUND PARTICIPATION - RECIPROCITY

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

2.3(n) RETIREES DEATH BENEFITS

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

- be enrolled in the Retirees Plan; and
- file a completed *Application for Enrollment* by the later of 90 Days after his MCTWF Retirees Plan Retirement Date or 30 Days after the date of the Fund's letter approving the *Application for Enrollment* in the Retirees Plan.

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

- be enrolled in the Retirees Plan; and
- file a completed *Application for Enrollment* by the later of 90 Days after the Retiree's MCTWF Retirees Plan Retirement Date or 30 Days after the date of MCTWF's letter approving the *Retiree Death Benefit Application* in the Retirees Plan.

Special Circumstances

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

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

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

Enrolling

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

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

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

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

Contributions

Quarterly Contributions under the Retirees Death Benefit will be based on the individual's (Retiree or Spouse) age at the time of the Retiree's initial participation in the MCTWF Retirees Plan. The first Contribution for a three-month period (quarter) must be filed with the Fund along with the completed *Retirees Death Benefit Election Form*. Thereafter, Contributions must be paid for each successive quarter and must be filed with the Fund on or before the 20th

day of the month preceding the quarter for which payment is due. Upon receiving a quarterly Contribution, the Fund will send a statement to the Retiree and/or Spouse for the following quarter. Contributions will not be accepted beyond the current quarterly Contribution period due. All Contributions received must include the social security number of each eligible Participant. Failure by the Fund to provide a statement for quarterly Contributions does not relieve a Retiree or Spouse from the obligation to make timely Contributions.

It is the responsibility of each Retiree and/or Spouse to send timely payments to the Fund. Coverage under the Retirees Death Benefit will terminate if Contributions are not filed with the Fund within the time required. Late Contributions will be accepted if payment for the quarter past due is received by the 15th of the month following the quarter due, together with a \$50 late fee. Participants who have not made payment by the last business day of the quarter for which a payment is due will be sent a late notice reflecting the above. If the required payments are not received by the 15th of the month following the quarter due, coverage will be terminated, regardless of the reason(including non-receipt of the late notice). There will be no reinstatement of coverage under the Retirees Death Benefit following termination. Contributions are non-refundable upon the termination of coverage under the Retirees Death Benefit. Furthermore, Contributions attributable to unexpired portions of a quarter are not refundable upon the termination of coverage under the Retirees Death Benefit.

Medical benefits under the MCTWF Actives Plan and MCTWF Retirees Plan may be subject to Deductible, Copayment and Coinsurance amounts. Each of these terms are defined in the glossary at the end of this Booklet. The MCTWF Actives Plan and MCTWF Retirees Plan may also provide for limits on your Annual exposure to Coinsurance amounts (i.e., an Out-of-Pocket Maximum).

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

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

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

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

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

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

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

described above. All claims for Out-of-Network services must be submitted to the local BCBS Plan for payment

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

All medical claims for services rendered by non-Blue Cross Blue Shield participating providers are referred by the Fund to Consilium, an expert bill negotiation vendor, with the goal of eliminating balance billing to You by the provider through Consilium's negotiation of a settlement with it. If Consilium, the negotiation vendor is unsuccessful, it determines whether the provider belongs to one or more of 150 provider networks and therefore subject to contractual limits on its charges. If either approach is successful, your financial responsibility only will be for the payment of your required deductible and or coinsurance charge. However, since Consilium's negotiation is likely to result in lower payment to the provider (and therefore a lower coinsurance charge to You) than would a network contractually based amount, and since Consilium the negotiation vendor negotiates a bill that You have already paid, the Fund urges 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.

All participants and spouses covered by a MCTWF medical benefits package received new MCTWF Networks Cards in 2015. While MCTWF urges you to use a Blue Cross Blue Shield participating provider whenever possible to avoid your exposure to balance billing for amounts greater than MCTWF maximum allowable benefits, as stated in the notice that accompanied the Cards, effective July 1, 2015, all unpaid medical claims for services rendered by non-Blue Cross Blue Shield providers were 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. MCTWF urges 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.

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

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

3.1(a) WORLDWIDE NETWORK PROVIDERS

The Blue Cross Blue Shield Global Core® program (formerly known as BlueCard Worldwide®) gives 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 (800) 810-2583, or collect at (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, 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.

3.1(b) CERTAIN OUT-OF-NETWORK PROVIDER SERVICES COVERED AT IN-NETWORK LEVELS

The below listed provider categories do not participate in the BCBS PPO Network, but do participate in the BCBS Traditional Network. Services obtained from BCBS Traditional Network providers in the following categories will be Covered at in-network benefit levels:

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

*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 it constitutes a medical necessity.

The Consolidated Appropriations Act 2021 (CAA), also known as the No Surprises Act, provides for continuity of care and identifies a continuing care patient as an individual who –

- is undergoing a course of treatment for a serious and complex condition from a provider or facility;
- is undergoing a course of institutional or inpatient care from a provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including postoperative care;
- is pregnant and undergoing a course of treatment for the pregnancy from a provider or facility; or
- is or was determined to be terminally ill and is being treated by a provider or facility.

Effective April 1, 2022 dates of service and after, if a continuing care patient is receiving care with an BCBS PPO network provider or facility and the contractual relationship with the provider or facility is terminated for any reason other than for-cause termination of the provider, the CAA requires the Plan to notify members when a provider or facility leaves the BCBS PPO Network and notify the member of their right to elect continued transitional care from the provider or facility, and to continue to provide the same level of in network benefits for 90-days or until the end of the treatment plan, whichever occurs first, for qualified members.

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

3.2(a) MEDICAL CARE

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

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

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

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

3.2(b) NON-ACCESS EXEMPTION APPLICATION

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

SEC. 3.3: USING YOUR IDENTIFICATION CARDS

You should present your MCTWF Networks Card and your Blue Cross ID card at the time You receive medical services. Only your MCTWF Networks Card is necessary to receive services at participating pharmacies.

When You present your card for medical services, claims for the services will be sent directly to the local Blue Cross Blue Shield Plan for processing by the provider (see Sec. 13.1, Claims for Medical Benefits - Actives and Retirees, for information about filing claims for medical benefits).

SEC. 3.4: SCHEDULE OF BENEFITS

Your Schedule of Benefits contains information about the MCTWF Actives Plan or MCTWF Retirees Plan, including specific benefits and benefit types, Deductibles, Copayments, Coinsurances and benefit maximums.

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

3.5(a) ALLOWED AMOUNTS

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

3.5(b) DEDUCTIBLE

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

3.5(c) COINSURANCE

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

3.5(d) COPAYMENT

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

3.5(e) OUT-OF-POCKET MAXIMUM

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

3.5(f) MAXIMUM ALLOWABLE BENEFIT

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

SEC. 3.6: PRIOR AUTHORIZATION

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

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

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

Prior Authorization for Advanced Imaging and In-Lab Sleep Studies

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.

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 Blue Shield 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. 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.

SEC. 3.7: HOSPITAL

3.7(a) ROOM AND BOARD

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

3.7(b) OTHER HOSPITAL SERVICES

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

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

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

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

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

SEC. 3.8: SURGICAL

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

SEC. 3.9: SECOND AND THIRD MEDICAL OPINIONS

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

SEC. 3.10: DIAGNOSTIC IMAGING

The MCTWF Actives Plan and MCTWF Retirees Plan pays for diagnostic imaging services.

SEC. 3.11: LABORATORY TESTS

The MCTWF Actives Plan and MCTWF Retirees Plan pays for laboratory tests.

Selecting a Lab for In-Network Benefits

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.

SEC. 3.12: PHYSICIAN VISITS

The MCTWF Actives Plan and MCTWF Retirees Plan pays for Physician's office visits and in-Hospital Physician visits.

SEC. 3.13: SKILLED NURSING FACILITY

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

SEC. 3.14: EMERGENCY SERVICES

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

For claims with dates of service from March 31, 2022, and prior, an emergency is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm. Some examples of such emergency Illnesses are heart attack, strokes, loss of consciousness and convulsion. Some examples of emergency Accidental Injuries are severe eye or head injury, medication overdose, poison ingestion, severe allergic reaction, animal bite, burn, smoke inhalation, and frostbite.

In accordance with the Consolidated Appropriations Act (No Surprises Act), effective with dates of service on or after April 1, 2022, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

In general, emergency room treatment for medical conditions that do not require immediate attention (to prevent death or serious bodily harm), including chronic medical problems, is not covered as a benefit. However, the Fund has made arrangements with Blue Cross Blue Shield of Michigan that will avail members of BCBS discounts. The Fund will “approve” emergency room facility claims and emergency room physician claims for treatment of non-emergent conditions, thereby triggering the BCBS discounts. The Fund will continue not to pay any portion of the non-emergent emergency room facility claims, but will make payment toward the non-emergent emergency room physician claims in an amount approximately equivalent to what the Fund would have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by the Fund’s payment at the urgent care rate for those services

For conditions that require medical attention and cannot wait for an appointment with your physician, but are not “emergent,” treatment should be sought from an urgent care center. All emergency room claims incurred by individuals greater than three per 12 month period are reviewed by the Fund’s Medical Director for medical necessity. Should the use of the emergency room be determined to not have been medically necessary, You will be responsible for payment as noted above.

SEC. 3.15: AMBULANCE SERVICES

The MCTWF Actives Plan and MCTWF Retirees Plan pays eligible expenses for ground, air or water licensed ambulance services for basic and advanced life support. Eligible expenses include the basic charge for the trip, basic life support service (BLS), limited advanced life support services, advanced life support services (ALS), specialty care transport (SCT) neonatal transportation services, mileage, oxygen, administration and other non-reusable supplies, and waiting time. The service must be medically necessary and transport by any other means would endanger the patient's health or life. Eligible services include supplies, transportation to a medical facility for treatment of a medical emergency, the injury (ies) require(s) immediate first aid to stabilize the patient before transport to a hospital, or to transfer the patient from a hospital to another treatment location, including treatment at another hospital, skilled nursing facility, a medical clinic or the patient's home. It is the Fund's intent to hold harmless from balance billing exposure, participants and beneficiaries who, in seeking emergency ambulance services, receive services from a non-participating ambulance provider, when no other reasonable choice is available.

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

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

Ambulance services are payable without transport in the following situations:

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

SEC. 3.16: MATERNITY

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

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

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.

3.16(a) NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's

attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from your plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3.16(b) MIDWIFE SERVICES

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

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

SEC. 3.17: HOME HEALTH CARE

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

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

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

3.17(a) HOME CERVICAL TRACTION DEVICES

Cervical Traction can be performed safely at home in lieu of receiving such treatment at a physical therapist's office. 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 chin halter is unable to be utilized.

3.17(b) NURSING CARE

The MCTWF Actives Plan and MCTWF Retirees Plan pays for graduate registered nurse (RN) services and licensed practical nurse (LPN) services, including private-duty nursing, as long as the service is not provided by a family member, and the services have the Fund's prior authorization as part of the home health care benefit.

Services of home health care nurses are limited as follows:

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

SEC. 3.18: HOSPICE

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

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

SEC. 3.19: RESPITE CARE

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

SEC. 3.20: CHIROPRACTIC SERVICES

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

- Nonallopathic lesions -
 - cervical region;

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

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

SEC. 3.21: OPHTHALMOLOGY AND OPTOMETRY SERVICES

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

SEC. 3.22: HEARING

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

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

3.22(a) COVERED HEARING AID ITEMS

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

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

3.22(b) HEARING AID ITEMS NOT COVERED

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

batteries;

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

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

SEC. 3.23: DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment (DME) is equipment that can withstand repeated use and is primarily

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

A full list of Covered DME equipment can be found on the Schedule of Benefits page of the Fund's website.

The following types of equipment are not considered DME and are examples of non-Covered items:

- comfort or convenience items;
- exercise and hygienic equipment;
- Physician's equipment;
- self help devices;
- spare equipment; and
- disposable equipment.

SEC. 3.24: MEDICAL SUPPLIES

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

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

SEC. 3.25: WELLNESS

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

3.25(a) TYPES OF COVERED SERVICES

For women, your Fund wellness benefit pays for the following:

Screening:

- mammography screening - one baseline screening between the ages of 35 and 40 years and one screening annually age 40 years and older*;
- cervical cancer screening (Pap smear) - once annually;

- chlamydia and gonorrhea
- blood pressure
- cholesterol
- colon cancer
- depression
- diabetes
- lung cancer

Other services:

- contraception
- immunizations as required by the Affordable Care Act (ACA)
- obesity screening and counseling
- tobacco cessation
- sexually transmitted infection (STI) counseling
- physical examination - once annually;
- gynecologic pelvic examination - once annually;
- electrocardiogram (EKG) - once annually;
- stool occult blood tests - once annually age 50 years and older;
- colonoscopy or flexible sigmoidoscopy screening - once every five Years age 45 years and older. On a one time only basis, if the colonoscopy follows a sigmoidoscopy, the five year limitation does not apply;
- bone density testing - once for menopausal women, with follow-up testing once every two years;
- Human Papillomavirus (HPV) immunization - one series between the ages of 18 and 45, if was not received between ages 9 and 18;
- Human Papillomavirus (HPV) Annual DNA testing for women age 30 or older; and
- influenza vaccination - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

*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.

For pregnant women, your Fund wellness benefit pays for the following:

Screening:

- bacteria in urine
- gestational diabetes
- Hepatitis B
- iron deficiency anemia
- postpartum depression

Other Services:

- breastfeeding support, supplies and counseling
- folic acid supplementation

For men, your Fund wellness benefit pays for the following:

Screening:

- abdominal aortic aneurysm

- blood pressure
- cholesterol
- colon cancer
- depression
- diabetes
- lung cancer

Other Services:

- immunizations as required by the Affordable Care Act (ACA)
- obesity screening and counseling
- tobacco cessation
- sexually transmitted infection (STI) counseling
- Prostate Specific Antigen (PSA) tests - once annually age 40 years and older;
- stool occult blood tests - once annually age 50 years and older;
- physical examination - once annually;
- colonoscopy or flexible sigmoidoscopy screening - once every five Years age 45 years and older. On a one time only basis, if the colonoscopy follows a sigmoidoscopy, the five year limitation does not apply;
- electrocardiogram (EKG) - once annually; and
- influenza vaccination - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.
- Human Papillomavirus (HPV) immunization - one series between the ages of 18 and 45, if was not received between ages 9 and 18.

For infants, children and teens, your Fund wellness benefit pays for the following:

- well baby/child physical examinations - one examination in conjunction with each of the age recommended immunizations; newborn and infant screenings
- physical examination - no more than once annually including examinations in conjunction with immunizations;
- Electrocardiogram (EKG) - once annually ages 12-18 years and older as part of a child physical examination; and
- immunizations - the type and frequency recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, including the flu shot.
- hearing/vision test
- oral health check
- depression screening
- lead exposure test
- tobacco and alcohol use counseling
- sexually transmitted infections (STI) screening and counseling
- obesity counseling

SEC. 3.26: OTHER MEDICAL BENEFITS

3.26(a) APPLIED BEHAVIOR ANALYSIS

The MCTWF Actives Plan pays for Applied Behavior Analysis (ABA) services under the following conditions for dependent children through age 18 diagnosed with an autism spectrum disorder. Effective with service dates of January 1, 2016 and after, all limits on MCTWF Applied Behavior Analysis (ABA) coverage were eliminated.

The requirements which must be satisfied for coverage of ABA services are as follows:

- Services in Michigan – An approved Blue Cross Blue Shield of Michigan (BCBSM) autism evaluation center must make or confirm the autism spectrum disorder diagnosis and provide a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services, before treatment begins. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst may be non-participating but must be registered with BCBSM. A link to Approved Autism Evaluation Centers and Board-Certified Behavior Analysts is available on the Info Links page of the Fund's website.
- Services Outside of Michigan – The participant must obtain a multidisciplinary evaluation from an academic medical center or a hospital based facility (participating with the Blue Cross Blue Shield plan in the state where services will be provided) that makes or confirms the autism spectrum disorder diagnosis and provides a treatment plan containing a comprehensive set of treatment recommendations for the patient, including a recommendation for ABA services. If ABA treatment is recommended, the services must be obtained from a board-certified behavior analyst for the treatment to be payable. The analyst must obtain prior authorization from BCBSM to provide ABA services. The board-certified behavior analyst must be a participating provider in the Blue Cross plan in the state where services will be

provided. A link to Blue Cross Blue Shield Non-Michigan Physician, Hospital and Urgent Care Searches is available on the Provider Networks page of the Fund's website.

ABA Services	Limitations
Initial Assessment	Once per patient
Reassessment	No limitation
Line Therapy in combination with skills training services	Limited to 25 hours per patient per 7 days (Sunday-Saturday)
Skills Training in combination with line therapy services	Limited to 25 hours per patient per 7 days (Sunday-Saturday)
Supervision	Limited to 3 hours per patient per 7 days (Sunday-Saturday)
Caregiver Training	Limited to 3 hours per patient per 7 days (Sunday-Saturday)

3.26(b) BARIATRIC SURGERY

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

- The patient has a body mass index (BMI) of 40 or greater. If the patient's BMI is between 35 and 39, authorization will be granted if one or more co-morbid conditions also exist, including but not limited to:
 - degenerative joint disease (including degenerative disc disease)
 - hypertension
 - hyperlipidemia or coronary artery disease
 - other atherosclerotic diseases

- type II diabetes mellitus
- sleep apnea
- congestive heart failure.
- The patient has been clinically evaluated by a physician (or authorized delegate) and the physician has documented the failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of six consecutive months within the last four years prior to the recommendation for bariatric surgery. However, this requirement is waived for super morbidly obese individuals (i.e., those who have a BMI of 50 or greater). Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated.
- Documentation has been provided demonstrating that the physician and the patient have a good understanding of the risks involved and that the physician has a reasonable expectation that the patient will be compliant with all post-surgical requirements.
- The patient has had a psychological evaluation performed as a pre-surgical assessment by a mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of the surgery and to give informed consent, and ability to cope with expected post-surgical lifestyle.

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

3.26(c) BREAST RECONSTRUCTION

If You have a mastectomy, the MCTWF Actives Plan and MCTWF Retirees Plan pays for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas; and
- a maximum of four mastectomy bras per calendar year.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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.

3.26(d) BREAST REDUCTION MAMMOPLASTY

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

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

- The amount of tissue to be removed must be greater than or equal to the 22nd percentile on the Schnur Sliding Scale.
- Two of the below requirements must be met:
 - Documented pain in the neck and/or shoulders, or postural backache, which must be of long-standing duration. Failure of conservative therapy, including an appropriate support bra, exercises, heat/cold treatments and appropriate non-steroidal anti-inflammatory agents or muscle relaxants.
- Shoulder grooving.
- Recurrent intertrigo between the breasts and the chest wall that has not responded to dermatologic treatment.

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

3.26(e) CARDIAC REHABILITATION

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

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

3.26(f) CHEMOTHERAPY AND RADIATION THERAPY

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

3.26(g) COLONOSCOPY SCREENING

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 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.

On a one time only basis, if the colonoscopy follows a sigmoidoscopy, the five year limitation does not apply.

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. 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.

3.26(h) CONTRACEPTIVE MANAGEMENT

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

3.26(i) DENTIST AND DENTAL SURGEON SERVICES

The MCTWF Actives Plan and MCTWF Retirees Plan provide 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. 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.

3.26(j) DEVELOPMENTAL SPEECH THERAPY

The MCTWF Actives Plan pays for unlimited therapy designed to restore and maintain speech function (restorative speech therapy). 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.

3.26(k) DIALYSIS

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

3.26(l) DIETARY COUNSELING

The MCTWF Actives Plan and MCTWF Retirees Plan pays for unlimited dietary counseling by a certified dietician for certain diagnostic categories. To obtain a list of Covered categories contact the Fund's Member Services Call Center.

3.26(m) GASTRIC ECHOCARDIOGRAPHY SERVICES

The MCTWF Actives Plan and MCTWF Retirees Plan pays for expansion of its current radiology management program by requiring prior authorization of non-emergency outpatient echocardiography services performed in a physician's office, freestanding radiology center, or hospital outpatient setting (but not in a in the hospital inpatient, observation, or emergency room setting). Michigan providers must obtain prior authorization by contacting AIM Specialty Health (see Important Phone Numbers). Non-Michigan providers must obtain prior authorization by contacting the Fund's Utilization Review department (see Important Phone Numbers). If services are performed, but not prior authorized, the participant may be responsible for full payment of charges.

3.26(n) EXPERIMENTAL, INVESTIGATIVE OR OTHERWISE NOT REASONABLE OR CUSTOMARY TREATMENT

The MCTWF Actives Plan and MCTWF Retirees Plan pays for Medically Necessary services to correct complications arising out of Experimental, Investigative or otherwise not reasonable or customary treatment.

3.26(o) GASTRIC ELECTRICAL STIMULATION THERAPY

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

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

3.26(p) HYPERALIMENTATION (TPN)

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

3.26(q) INFUSION THERAPY

The MCTWF Actives Plan and MCTWF Retirees pays for infusion therapy services for a course of treatment.

3.26(r) INJECTIONS

The MCTWF Actives Plan and MCTWF Retirees Plan pays for injections (e.g., allergy, antibiotic, contraceptive), when administered to treat a medical condition.

3.26(s) IMMUNIZATIONS

The MCTWF Actives Plan and MCTWF Retirees Plan pays for adult immunizations as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

3.26(t) INTRA-ARTICULAR INJECTIONS

The MCTWF Actives Plan and MCTWF Retirees Plan pays for limited coverage for intra-articular injections of the knee for participants with the following conditions:

- osteoarthritis, localized, primary, lower leg;
- osteoarthritis, localized, secondary, lower leg; and
- osteoarthritis, localized, not specified whether generalized or localized, lower leg.

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

3.26(u) ORTHOTIC DEVICES

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

In addition to the exclusions listed in the General Exclusions and Limitations (see Part 1) and Medical Expenses Not Covered (see Sec. 3.33) sections of this Booklet, the following orthotic devices may be excluded as well:

- arch supports or supportive devices for the feet;
- orthotic devices used for participating in strenuous physical activity beyond normal activities or daily living;
- orthopedic or corrective shoes (except when either one of both are an integral part of a leg brace); or
- non-rigid applications such as elastic stockings, corsets or garter belts.

3.26(v) PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

The MCTWF Actives Plan and MCTWF Retirees Plan pays for physical, occupational and speech therapy when You require therapy to restore and maintain normal function.

Note: Since for congenital type diagnoses, therapy is required to develop and maintain function rather than to restore and maintain function, it is not Covered under your MCTWF Actives Plan or MCTWF Retirees Plan.

3.26(w) PROSTHETIC DEVICES

The MCTWF Actives Plan and MCTWF Retirees Plan pays for prosthetic devices when prescribed by your Physician and obtained from a provider who Blue Cross Blue Shield (BCBS) has certified as a prosthetic device supplier.

3.26(x) SLEEP STUDIES

The MCTWF Actives Plan and MCTWF Retirees Plan pays for sleep studies for the following diagnoses:

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

- cataplexy and narcolepsy.

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

3.26(y) SCLEROTHERAPY

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

3.26(z) SPECIAL FORMULAS AND MEDICAL FOODS - MCTWF Actives Plan

The MCTWF Actives Plan pays for special formulas and medical foods prescribed for infants and young children born with certain inherited metabolic diseases per the following:

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

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

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

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

3.26(aa) TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

The MCTWF Actives Plan and MCTWF Retirees Plan pays for services related to the diagnosis and medical treatment of temporomandibular joint dysfunction.

3.26(bb) RECONSTRUCTIVE SURGERY TO REMOVE EXCESS SKIN

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.

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).

SEC. 3.27: MCTWF ACTIVES PLAN EXTENDED DISABILITY

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.

SEC. 3.28: HUMAN ORGAN TRANSPLANT

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

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

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

3.28(a) COVERED EXPENSES

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

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

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

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

Specified Organ Transplant Program

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

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

Note: Additional approved transplants that You may require during phase III as a replacement of a previous transplant are considered a separate transplant.

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

your MCTWF Actives Plan or MCTWF Retirees Plan benefit package) for as long as You are Covered under the MCTWF Actives Plan and MCTWF Retirees Plan.

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

3.28(b) ORGAN TRANSPLANT DONOR COVERED EXPENSES

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

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

SEC. 3.29: MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT

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

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

SEC. 3.30: TELEHEALTH AND DIGITAL SERVICES

MDLIVE is 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. MDLIVE physicians are state licensed and Board certified and are credentialed in family practice, internal medicine, pediatrics, or emergency medicine. MDLIVE physicians average 15 years of experience. The goal is to connect You with the care You need, whenever You need it. Whether You are at home, at work, traveling, or You simply want the most convenient way to see a doctor, real-time video and phone consultations allow for the diagnosis and treatment of a wide range of medical conditions, regardless of your location, in a safe, secure and confidential environment.

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

When To Use MDLIVE:

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

Common Conditions Treated:**Medical**

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

Behavioral Health

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

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

When activating your account online -

1. The participant must activate their account before eligible family members can be activated. The participant must enter the last 4 digits of his social security number and his date of birth, continue to the next screen to select name from among his listed family members, and then continue to each of the patient sign-up screens, creating a username and a password and filling in other requested information.
2. An e-mail confirmation will be sent to the participant. Once received, the participant will complete the activation process by clicking on the activation link. Then he will be prompted to login using his username and password. This will take him to his personal portal's "Dashboard."
3. The participant now may register each dependent minor child in the same manner that he did for himself by selecting each name from the drop down next to the participant's name in the upper right hand corner of the Dashboard screen. The participant's spouse and children over age 18 may register by using the participant's last 4 digits of his social security number and his date of birth and then following the above process for themselves.
4. Each registered person should fill out his medical history by clicking on the link, "My Health" on the left hand side of their Dashboard page and then completing all of the tabs under "My Health."
5. Also to the right hand side of your Dashboard is the link, "You need to choose a pharmacy." Each registered person should select the network pharmacy to which he wishes his prescriptions sent. MDLIVE physicians have been asked to observe the Fund's prescription benefit rules and limitations apply when prescribing medications.

Requesting a medical or behavioral health consultation, by phone or online -

If arranging for a consultation online, sign in using the username and password You created to be directed to your Dashboard from where You can seek a phone consultation with the next available "on call" doctor or therapist available, or You can select from a number of family

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

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

Telehealth Benefit Expansion

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.

Livongo® for Diabetes Management Program

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 or call Livongo Member Support at (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® DIABETES PREVENTION PROGRAM

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 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. Your participation and progress in Omada’s Prediabetes Program are strictly confidential.

SEC. 3.31: COVERAGE FOR MEDICALLY NECESSARY TRANSSEXUAL SERVICES

Effective with dates of services September 1, 2016, 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:
 - o Genitalia reconstruction
 - o 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 a mastectomy.
- 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;
- 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.

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:

- o Abdominoplasty - o Blepharoplasty - o Breast enhancements - o Brow lift - o Calf implants - o Cheek/malar implants - o Chin/nose implants - o Chondrolaryngoplasty (Adam's apple) - o Collagen injections - o Construction of a clitoral hood - o Drugs for hair loss or reduction - o Collagen injections	- o Drugs for hair loss or growth - o Forehead lift - o Hair removal - o Hair transplantation - o Lip reduction - o Liposuction - o Mastopexy - o Neck tightening - o Pectoral implants - o Removal of redundant skin - o Rhinoplasty - o Non-covered services
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*Hormonal therapy is not required prior to mastectomy in female-to-male patients.

SEC. 3.32 Coverage for Medically Necessary, Non-Implantable Contact Lenses

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.

SEC. 3.33: MEDICAL EXPENSES NOT COVERED

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

- massage therapy, or acupuncture;
- any vision correction services;
- dental treatment or operation;
- personal comfort items while hospitalized, including but not limited to telephones and televisions;
- the portion of a private room charge greater than the rate for a semi-private room unless Medically Necessary and ordered by your Doctor;
- surgical procedures, treatment or hospitalization primarily for cosmetic purposes;
- services to correct complications arising out of cosmetic procedures even when Medically

Necessary;

- any treatment or service not provided or ordered by a Physician;
- expenses that exceed specified benefit levels listed in your Schedule of Benefits;
- charges for care, treatment, services and supplies that are considered Experimental or Investigative in nature and/or not considered reasonable and customary by any government agency or subdivision (including as provided in the CMS Medicare Coverage Issues Manual), except Medically Necessary services to correct complications arising out of such services;
- expenses that exceed the Maximum Allowable Benefit amount, Contracted Charges or MCTWF Actives Plan and MCTWF Retirees Plan limits;
- any treatment, except dietary counseling, maternity and wellness care that is not the result of an Accidental Injury, Sickness or Illness;
- treatment for obesity when billed as an isolated diagnosis;
- medical or surgical therapies and procedures for infertility administered strictly for the purpose of conception;
- treatment for sexual impotency when the cause is mental or emotional;
- treatment of developmental disorders without a medical diagnosis as the cause of mental and/or physical development;
- bundled services provided through structured pain control/rehabilitation programs;
- benefits for Beneficiaries in a Health Maintenance Organization (HMO) that were denied because the HMO guidelines were not followed;
- expenses for transportation or lodging, other than those Covered under the Specified Organ Transplant Program or Medically Necessary use of an ambulance;
- expenses for Custodial Care, whether on an inpatient, outpatient or home care basis;
- expenses for drugs or medical supplies that are available over-the-counter;
- expenses for prescription drugs (excluding injectables administered in the Physician's office or prescription drugs related to an approved transplant). However, these may be Covered under your prescription drug benefit;
- weight loss programs, except dietary counseling;
- charges for any service that requires prior authorization that was not prior authorized;
- charges for care, treatment, services and supplies that are not uniformly and professionally endorsed as standard medical care by the general medical community in the state where the treatment is rendered;
- charges for non-surgical spinal decompression therapy with services dates January 1, 2016 and after;
- charges for completion of claim forms or missed appointments;
- Deductible, Copayment and Coinsurance amounts applied for treatment, procedures, or services that were previously processed by the Fund;
- expenses sustained while participating in an illegal act which is in violation of a State or Federal Statute;
- charges for services after coverage has been terminated, except if You are an Actives Plan participant or Beneficiary Covered under the Extended Disability benefit;
- services rendered by a social worker or counselor who is not licensed in the state where services are performed;
- marriage or family counseling;
- expenses related to a transplant of an animal organ or a mechanical device to replace a human organ;
- charges You are not legally required to pay;
- charges for dyschromia (tattoo removal);
- charges for stand-by surgeons;
- charges for non-Physician surgical assistants;

- charges for educational programs or materials (except as identified as covered dietary counseling);
- separate charges for sales tax, surcharges and/or shipping charges;
- immunizations required for foreign travel;
- hair prosthesis, hair transplants or implants and wigs;
- expenses for employment ordered medical services;
- expenses for military service related conditions or injuries; or
- preventable Hospital acquired conditions and serious adverse events.
- 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.

SEC. 3.34: REQUESTS FOR MEDICAL RECORDS

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.

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.

SEC. 4.1: HOW YOUR PLAN PAYS BENEFITS

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

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

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

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

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

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

- the Participant returns to regular employment for at least 14 Days between disabilities; or
- the disabilities are due to unrelated causes and begin after his return to regular employment for at least one day.

SEC. 4.2: CONTINUATION OF BENEFIT ELIGIBILITY

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

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

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

SEC. 4.3: HOW BENEFITS ARE TAXED

The Participant's weekly accident and sickness benefits are subject to withholding for federal FICA (Social Security) tax purposes.

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

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

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

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

SEC. 5.1: BENEFIT AMOUNT AND DURATION

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

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

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

The Fund has the right to recover any TPD benefits a Participant receives after he is no longer eligible for this benefit. The Fund may recover these overpayments by reducing future benefits the Participant is entitled to receive under his MCTWF Actives Plan.

The Fund provides You with prescription drug coverage for prescription fills by a retail pharmacy of up to a 34 day supply or for a 35-90 day supply, for prescription fills by a mail service pharmacy of up to a 90 day supply, and for prescription fills by a specialty pharmacy of up to a 90 day supply.

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

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

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

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

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

6.1(a) FILLING A PRESCRIPTION AT A RETAIL PHARMACY

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

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

Glucose Monitoring Supplies

You may obtain prescribed lancets, test strips and glucose meters from any participating Network pharmacy at your MCTWF Actives Plan or MCTWF Retirees Plan's benefit package Brand Name Drug Copayment or Coinsurance level. Starting January 1, 2021, covered meters include: OneTouch Verio Reflect®, OneTouch Verio Flex®, OneTouch Verio® and OneTouch Ultra 2®. All OneTouch test strips will have preferred formulary status.

SEC. 6.2: MAIL SERVICE PHARMACY

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

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

Ask your Physician to write two prescriptions. One prescription should be for up to a 34 Day supply, to fill at a participating retail Network pharmacy to ensure an immediate supply. The other prescription should be for up to a 90 Day supply, plus any appropriate refills.

Complete a *CVS/Caremark Mail Service Order Form* (available in your CVS/Caremark Prescription Benefit booklet, from the *Forms* page of the Fund's website or from our Member Services Call Center, and send it to CVS/Caremark, along with your original prescription(s) (not a photocopy), and the appropriate co-payment for each prescription. You must mail in a *Mail Service Order Form* each time You request a new prescription through the mail service pharmacy. The mail service pharmacy will process your order and send your medication to You within 14 Days along with re-order instructions for future prescriptions or refills. In addition to ordering your prescription refills by mail, You may also order online at www.caremark.com or by contacting CVS/Caremark.

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

Glucose Meters

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

Coverage for Non-Insulin Syringes

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.

Daily Low Dose Cialis Coverage Now Available Without Prior Authorization

Effective since 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.

SEC. 6.3: SPECIALTY PHARMACY SERVICES

Specialty pharmacy services provide specialty injectable, infusible and oral drugs for individuals with chronic or genetic conditions. Through this service You receive convenient mail delivery of

specialty medications, personalized service and educational support for your specific therapy. A team of professionals is assigned to help You successfully manage your condition and improve your quality of life. If You are prescribed a specialty medication and go to a retail pharmacy, the pharmacist will ask You to contact CVS/Caremark at (800) 237-2767, to initiate your direct relationship with specialty pharmacy services.

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

• Acromegaly	• Mental Health Conditions
• Alcohol/Opioid Dependency	• Migraine
• Allergen Immunotherapy	• Miscellaneous
• Alpha-1 Antitrypsin Deficiency	• Movement Disorders
• Amyloidosis	• Multiple Sclerosis
• Anemia	• Neutropenia
• Asthma	• Ocular Disorders
• Atopic Dermatitis	• Oncology-Injectable
• Botulinum Toxins	• Oncology – Oral/Topical
• Cardiac Disorders	• Osteoarthritis
• Coagulation Disorders	• Osteoporosis
• Cryopyrin-Associated Periodic Syndromes	• Paroxysmal Nocturnal Hemoglobinuria
• Cystic Fibrosis	• Phenylketonuria
• Electrolyte Disorders	• Pre-Term Birth
• Gastrointestinal - Other	• Psoriasis
• Gout	• Pulmonary Arterial Hypertension
• Growth Hormone and Related Disorders	• Rare Disorders - Other
• Hematopoietics	• Renal Disease
• Hemophilia, Von Willebrand Disease & Related Bleeding Disorders	• Respiratory Syncytial Virus
• Hepatitis	• Rheumatoid Arthritis
• Hereditary Angioedema	• Seizure Disorders
• Hormonal Therapies	• Sickle Cell Disease
• Human Immunodeficiency Virus (HIV)	• Sleep Disorders
• Immune Deficiencies and Related Disorders	• Systemic Lupus Erythematosus
• Infectious Disease - Other	• Thrombocytopenia
• Infertility	• Transplant
• Iron Overload	• Urea Cycle Disorders
• Lysosomal Storage Disorders	

6.3(a) SPECIALTY PREFERRED DRUG PROGRAM

CVS/Caremark's Advance Control Specialty Formulary Program expanded 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. If You are newly prescribed a "Non-Preferred" specialty medication for certain diseases in the following therapeutic classes the program requires that You be treated with the most common clinically effective medication:

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

If 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.

6.3(b) SPECIALTY MEDICAL CARVE-OUT PROGRAM

Effective January 1, 2016, MCTWF implemented, in limited form, CVS/Caremark's Specialty Medical Carve-Out 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.

6.3(c) PrudentRx Copay Program for Specialty Medications

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. MCTWF then reduces its cost for the medication and eliminates 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 out-of-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

SEC. 6.4: PRESCRIPTION DRUG PRIOR AUTHORIZATIONS

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

ABILIFY	ACANYA	ACIPHEX
ACIPHEX SPRINKLE	ACTEMRA ACTPEN	ACTEMRA INTRAVENOUS
ACTEMRA SUBCUTANEOUS	ACTICLATE	<i>Activite</i>
ACTOS	ACUVAIL	<i>acyclovir cream</i>
ADDERALL	ADRENALIN	ADZENYS ER
ADZENYS XR-ODT	AFINITOR	AIMOVIG
ALCORTIN A	ALEVICYN GEL	ALEVICYN SG
ALEVICYN SOLUTION	ALIQOPA	ALLISON MEDICAL INSULIN SYRINGES
ALPROLIX	ALREX	ALTOPREV
ALVESCO	AMITIZA	AMRIX
ANDROGEL	APEXICON E	APIDRA
APOKYN	APTENSIO XR	APTIVUS
ARALAST NP	ARANESP	ARTHROTEC
ASMANEX	ASMANEX HFA	ATACAND
ATACAND HCT	ATIVAN	ATOPADERM
ATRIPLA	ATRIPLA	AVASTIN
AVENOVA	AVSOLA	AZASITE
AZELEX	AZESCO	AZOR
BALCOLTRA	BANZEL SUSPENSION	BARACLUDE TABLET
BEAU RX	BECONASE AQ	BENICAR
BENICAR HCT	BENSAL HP	BENZACLIN
<i>benzonatate</i> (NDCs^ 69336012615, 69499032915 only)	BEPREVE	BERINERT
<i>betamethasone acetate-betamethasone sodium phosphate</i> (NDC^ 71283062002 only)	BETAMETHASONE ACETATE BETAMETHASONE SODIUM PHOSPHATE	BETAPACE
BETAPACE AF	BETIMOL	BEVESPI AEROSPHERE
BEYAZ	<i>bimatoprost solution 0.03%</i>	BORTEZOMIB
BOTOX	BREEZE 2 STRIPS AND KITS	BROMSITE
<i>budesonide ext-rel</i>	Bupap	<i>bupropion ext-rel tablet 450 mg</i>
<i>butalbital-acetaminophen tablet 50-300 mg</i>	BUTALBITAL-ACETAMINOPHEN (NDC^ 69499034230 only)	<i>butalbital-acetaminophen-caffeine capsule</i>
BUTRANS	BYDUREON BCISE	BYETTA
CAFERGOT	<i>calcipotriene cream</i>	<i>calcipotriene foam</i>
CALCIPOTRIENE FOAM	<i>calcipotriene-betamethasone</i>	<i>calcitriol ointment</i>
CAMBIA	CARAC	CARAFATE
CARBINOXAMINE TABLET 6 MG	CARDIZEM	CARDIZEM CD

CARDIZEM LA	<i>carisoprodol 250 mg</i>	CARNITOR
CARNITOR SF	CELEBREX	
<i>chlordiazepoxide-clidinium</i> (NDCs^ 11534019701, 42494040901, 51293069601, 51293069610, 67877073101, 70700018501 only)	<i>chlorzoxazone 250 mg</i>	<i>chlorzoxazone 375 mg</i>
chlorzoxazone 500 mg (NDC^ 73007001303 only)	chlorzoxazone 750 mg	CIALIS
CICATRACE	CILOXAN	CIMZIA LYOPHILIZED POWDER
CIMZIA PREFILLED SYRINGE	CINRYZE	CIPRO HC
CIPRODEX	<i>clindamycin gel</i> (NDC^ 68682046275 only)	<i>clobetasol spray</i>
CLOBEX SPRAY	<i>clocortolone cream</i>	COLAZAL
<i>colchicine capsule</i>	COLCRYS	COMPLERA
CONSENSI	CONTOUR NEXT STRIPS AND KITS	CONTOUR STRIPS AND KITS
CONTRAVE	CORDRAN CREAM	CORDRAN LOTION
CORDRAN OINTMENT	CORDRAN TAPE	COREG CR
<i>CoreMino</i>	COZAAR	CRESEMBA
CRESTOR	CUPRIMINE	cyclobenzaprine ext-rel capsule
cyclobenzaprine tablet 7.5 mg	CYMBALTA	CYTOMEL
DARAPRIM	DAYTRANA	DELZICOL
DESFERA	<i>desoximetason ointment 0.05%</i>	DETROL LA
<i>dexchlorpheniramine</i>	Dexifol	DIFFERIN LOTION
<i>diflorasone cream</i>	<i>diflorasone ointment</i>	<i>dihydroergotamine spray</i>
<i>diltiazem ext-rel (generics for CARDIZEM LA only)</i>	DIOVAN	DIOVAN HCT
Diphen Elixir	DORYX	DORYX MPC
<i>doxepin cream</i>	<i>doxycycline hyclate delayed-rel tablet 50 mg</i>	<i>doxycycline hyclate delayed-rel tablet 100 mg</i>
<i>doxycycline hyclate delayed-rel tablet 200 mg</i>	<i>doxycycline hyclate tablet 50 mg</i> (NDC^ 72143021160 only)	<i>doxycycline hyclate tablet 75 mg</i>
<i>doxycycline hyclate tablet 150 mg</i>	<i>doxycycline monohydrate capsule 75 mg</i>	<i>doxycycline monohydrate capsule 150 mg</i>
doxycycline monohydrate delayed-rel capsule	DULERA	DUTOPROL
DYRENIUM	EDARBI	EDARBYCLOR
E.E.S. GRANULES	EFFEXOR XR	ELELYSO
ELIDEL	ELIQUIS	ELMIRON
ENLITE CONTINUOUS GLUCOSE MONITORING SYSTEM	ENTERAGAM	ENTYVIO (For Crohn's Disease Only)
EPICERAM	EPOGEN	<i>ergotamine-caffeine</i>
ERYPED	estradiol vaginal tablet	ESTRING
EVEKEO	EVERSENSE CONTINUOUS GLUCOSE MONITORING SYSTEM	EXFORGE
EXFORGE HCT	EXJADE	EXTAVIA
FABIOR	FANAPT	FEIBA
FEMRING	<i>fenofibrate capsule 50 mg</i>	<i>enofibrate capsule 130 mg</i>
<i>enofibrate tablet 40 mg</i>	<i>fenofibrate tablet 120 mg</i>	FENOGLIDE TABLET 120 MG
enoprofen	FENOPROFEN CAPSULE	FERIVA 21/7
FERRIPROX	Fexmid	FINACEA GEL
FIORICET CAPSULE	FLAREX	flucytosine capsule 500 mg
<i>luocinonide cream 0.1%</i>	<i>fluorouracil cream 0.5%</i>	<i>fluoxetine tablet (generics for SARAFEM only)</i>
<i>fluoxetine tablet 60 mg</i>	<i>flurandrenolide cream</i>	<i>flurandrenolide lotion</i>
<i>flurandrenolide ointment</i>	FML FORTE	FML LIQUIFILM
FML S.O.P.	FOCALIN XR	FOLIC-K
FOLLISTIM AQ	<i>Folvite-D</i>	FORTAMET
FORTESTA	FOSRENOL	FOSTEUM
FOSTEUM PLUS	FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING SYSTEM	FREESTYLE STRIPS AND KITS
FULPHILA	GEL-ONE	<i>Genicin Vita-S</i>

GLASSIA	GLEEVEC	GLUMETZA
GLYCOPYRROLATE TABLET 1.5 MG	GOLYTELY	GRANIX
GUARDIAN CONNECT CONTINUOUS GLUCOSE MONITORING SYSTEM	GUARDIAN REAL-TIME CONTINUOUS GLUCOSE MONITORING SYSTEM	HAEGARDA
<i>halcinonide cream</i>	HALOG	<i>heparin sodium in 5% dextrose</i>
HEPARIN SODIUM IN 5% DEXTROSE	HERCEPTIN	HERCEPTIN HYLECTA
HORIZANT	HUMALOG	HUMALOG MIX 50/50
HUMALOG MIX 75/25	HUMATROPE	HUMULIN 70/30
HUMULIN N	HUMULIN R	HYALGAN
<i>hydrocortisone butyrate lipophilic cream 0.1%</i>	<i>hydrocortisone butyrate lotion</i>	<i>HylaVite</i>
<i>hyoscyamine sulfate ext-rel</i>	HYSINGLA ER	HYZAAR
ICLUSIG	<i>icosapent ethyl</i>	ILUMYA
INCRUSE ELLIPTA	INDERAL LA	INDERAL XL
INDOCIN	<i>indomethacin capsule 20 mg</i>	<i>Inflammacin</i>
INFLECTRA	INNOPRAN XL	INTRAROSA
INTUNIV	INVELTYS	INVIRASE
INVOKAMET	INVOKAMET XR	INVOKANA
<i>isosorbide dinitrate 40 mg</i>	<i>ivermectin cream</i>	JADENU
JALYN	JENTADUETO	JENTADUETO XR
KAMDOY	KAZANO	<i>ketconazole foam 2%</i>
<i>Ketodan</i>	<i>ketoprofen capsule 25 mg</i>	<i>ketoprofen ext-rel capsule</i>
KINERET	KOMBIGLYZE XR	KUVAN
KYPROLIS	LACRISERT	<i>Lactojen</i>
LACTULOSE PAK	LANOXIN TABLET (125 MCG and 250 MCG only)	<i>lanthanum carbonate</i>
LANTUS	LASTACAPT	LAZANDA
LESCOL XL	LETAIRIS	LEUKINE
<i>levorphanol</i>	LEXAPRO	LEXIVA
LIALDA	LIBRAX	
LIDOCAINE-TETRACAINE CREAM (NDC^ 71800063115 only)	LIDOTREX	LIPITOR
LITHOSTAT	LIVALO	<i>Lorid</i>
<i>Lorzone</i>	LOTEMAX	LOTEMAX SM
<i>luliconazole</i>	LUNESTA	LUPRON DEPOT
LYRICA	MACRODANTIN	<i>Matzim LA</i>
MAVYRET	MAXALT	MAXALT-MLT
<i>mefenamic acid (NDC^ 69336012830 only)</i>	<i>meloxicam capsule</i>	MENEST
<i>mesalamine delayed-rel tablet 800 mg</i>	<i>metaxalone 400 mg</i>	<i>metformin ext-rel (generics for FORTAMET and GLUMETZA only)</i>
<i>methocarbamol 500 mg (NDC^ 69036091010 only)</i>	<i>methocarbamol 750 mg (NDCs^ 69036093090, 70868090190 only)</i>	MIACALCIN INJECTION
MICARDIS	MICARDIS HCT	<i>Migergot</i>
MILLIPRED	MINASTRIN 24 FE	MINIVELLE
<i>minocycline ext-rel</i>	MIRVASO	<i>Mondoxylene NL capsule 75 mg</i>
MONOVISC	MOVIPREP	MULPLETA
<i>MultiPro</i>	<i>mupirocin cream</i>	MYTESI
NAPRELAN	<i>naproxen CR</i>	<i>naproxen suspension</i>
<i>naproxen-esomeprazole</i>	NATURE-THROID	NEO-SYNALAR
NESINA	NEULASTA	NEULASTA ONPRO
NEUPOGEN	NEVANAC	NEXIUM
<i>niacin tablet 500 mg</i>	<i>Niacor</i>	NICADAN
NICAPRIN	NICAZEL	NICAZEL FORTE

NICOMIDE	NILANDRON	<i>nitrofurantoin (NDCs^ 16571074024, 70408023932 only)</i>
<i>Nolix</i>	NORGESIC FORTE	NORITATE
NORPACE	NORVASC	NOURIANZ
NOVACORT	NOVO NORDISK NEEDLES	NOXAFIL
NPLATE	<i>NuDiclo SoluPak</i>	<i>NuDiclo TabPak</i>
NUTROPIN AQ	NUVARING	NUVIGIL
OLEPTRO	OLUX-E	<i>omeprazole-sodium bicarbonate</i>
OMNARIS	OMNITROPE	OMNIVEX
ONFI	ONGLYZA	ORENCIA CLICKJECT
ORENCIA INTRAVENOUS	ORENCIA SUBCUTANEOUS	<i>orphenadrine-aspirin- caffeine</i>
<i>Orphengesic Forte</i>	ORTHO D	ORTHO DF
ORTHOVISC	<i>Oscimin SR</i>	OSENI
<i>oxiconazole (NDCs^ 00168035830, 51672135902 only)</i>	OXYCONTIN	<i>oxymorphone ext-rel</i>
OXYTROL	<i>pantoprazole delayed-rel suspension</i>	<i>paroxetine HCl ext-rel (NDC^ 60505367503 only)</i>
<i>paroxetine mesylate capsule 7.5 mg</i>	PAXIL	PAXIL CR
PENNSAID	PERCOCET	PERRIGO NEEDLES
PEXEVA	PLAVIX	POLYTOZA
<i>posaconazole delayed-rel tablet</i>	PRADAXA	PRED FORTE
PRED MILD	PREMARIN	PREMARIN CREAM
PRENATAL PLUS	PREVACID	PREVIDENT
PRILOSEC	PRISTIQ	PROAIR HFA
PROMETRIUM	PROTONIX	PROVAD
PROVENTIL HFA	PROVIGIL	PROZAC
PSORCON	QNASL	QTERN
<i>quazepam</i>	RAPAFLO	RAYOS
RECEDO	REMODULIN	RENFLEXIS
REPATHA	RHEUMATE	RIABNI
RIBOZEL	RIMSO-50	RIOMET
RITUXAN	ROZEREM	<i>RyClora</i>
RYTARY	SABRIL	SAIZEN
SANDOSTATIN LAR	SCARSILK PAD	SEASONIQUE
SEROQUEL XR	SIGNIFOR LAR	SIL-K PAD
SILENOR	SILIVEX	SILTREX
SIMPONI	SINGULAIR	SOMAVERT
SORILUX	SPRIX	STENDRA
SUBOXONE	<i>sucralfate suspension</i>	<i>sumatriptan-naproxen</i>
SUPREP	<i>Symax-SR</i>	SYMJEPI
SYNERDERM	SYNVISC	SYNVISC-ONE
SYPRINE	TALIVA	TALTZ
<i>Targadox</i>	TASIGNA	<i>tavaborole</i>
TAYTULLA	TAZORAC	TECFIDERA
TESTIM	<i>testosterone gel 1% (authorized generics for TESTIM and VOGELXO only)</i>	THEO-24
THIOLA	THIOLA EC	TIMOPTIC OCULOSE
TIROSINT	TOBI	TOBI PODHALER
TOBRADEX ST	topiramate ext-rel capsule (generics for QUDEXY XR only)	TOPROL-XL
TRACLEER	TRADJENTA	ramadol (NDC^ 52817019610 only)
ramadol ext-rel capsule	TRANSDERM SCOP	TRAVATAN Z
TRELSTAR MIXJECT	TREXIMET	<i>triamcinolone aerosol 0.2%</i>
<i>triamcinolone ointment 0.05%</i>	<i>Trianex</i>	TRICOR
TRINAZ	TRIVIDIA INSULIN SYRINGES	<i>TronVite</i>

TRUVADA	TRUXIMA	TUDORZA
UDENYCA	ULORIC	ULTIMED INSULIN SYRINGES
ULTIMED NEEDLES	ULTRAVATE	UROXATRAL
VALCYTE	VALTREX	<i>Vanoxide-HC</i>
<i>venlafaxine ext-rel tablet (except 225 mg)</i>	VENTOLIN HFA	VEREGEN
VIAGRA	VIEKIRA PAK	VIIBRYD
VIRACEPT	VISCO-3	VITAFOL-ONE
<i>Vitasure</i>	VIVELLE-DOT	VOGELXO
WESTHROID	WP THYROID	XALKORI
XANAX	XANAX XR	XENAZINE
XENICAL	XOLEGEL	XOPENEX HFA
<i>Xvite</i>	XYZBAC	YASMIN
YAZ	<i>Yuvafem</i>	ZALVIT
ZARXIO	ZEGERID	ZELAC
ZEMAIRA	ZEPATIER	ZERVIAE
ZESTORETIC	ZETIA	ZETONNA
ZIANA	<i>zileuton ext-rel</i>	ZIRGAN
ZOHYDRO ER	ZOLADEX	ZOLOFT
<i>zolpidem sublingual</i>	ZOLPIMIST	ZONEGRAN
ZONTIVITY	ZORTRESS	ZORVOLEX
ZUPLENZ	ZYDELIG	ZYLET
ZYTIGA	ZYVIT	

Note: This list represents brand products in CAPS, branded generics in upper- and lowercase Italics, and generic products in lowercase italics that require prior authorization as of 1/1/22. This is not an all-inclusive list of available drug options. Log in to Caremark.com to check coverage and copay information for a specific drug. Discuss this information with Your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to Your doctor or health care provider about this information and any health-related questions You have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This list is subject to change. To keep up with current lists, visit www.mctwf.org/Information/info-links.

Opioid Utilization Management Strategy

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	- New initial limits for obtaining opioids without prior authorization up to 90 MME/day. - Quantities higher than initial limits require post-limit prior authorization; limited to a maximum of 200 MME/day.
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Prior Authorization Post-Quantity Limit Coverage Duration	• Post-limit prior authorization approvals: 1 month for acute pain; 12 months for chronic pain. • Prescriber to reassess patient response at least every three months. • Duration not limited for patients fighting cancer.
Step Therapy for Extended Release/Long Acting Opioid Analgesics for Chronic Pain	• For extended release opioid, trial and failure of immediate release opioid is first required. • 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.
10-Day Supply Duration Limit For Treatment of Acute Pain	• Immediate release opioids for acute pain limited to 10-day supply. • Beyond 10 days, additional supply provided when coverage conditions are met through prior authorization.
Increase Access to Treat Opioid Addiction	• Remove prior authorization (retain quantity limits) for buprenorphine combo products (buprenorphine-naloxone). • Prior authorization with quantity limits in place for buprenorphine mono products. Emergency supply is permitted when authorization is processed.

Prior Authorization and 90-Day Limits for Lidocaine Prescriptions

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 since 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.

Flu Shot and Affordable Care Act (ACA) Vaccines Available Under Prescription Drug Benefit At Network Pharmacies

On September 16, 2020, MCTWF mailed to members 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.

ACA Preventive Care Vaccines – Adults: Herpes 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 to find a network “vaccine pharmacy”) and to make an appointment. Please remember to present your white MCTWF Networks Card at the pharmacy.

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

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 – Due to the universal availability of over-the-counter NSAs, MCTWF coverage ceased in 2016, except that those patients who have an existing MCTWF authorization as of 12/31/15 have remain covered for the remainder of the authorization period, subject, of course, to otherwise maintaining eligibility for MCTWF prescription drug benefits.

Proton Pump Inhibitors – Patients are 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.

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

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

SEC. 6.7: COMPOUND DRUGS

In 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).

To obtain prior authorization for compound medications that exceed \$300, your physician must contact CVS/Caremark at (800) 626-3046.

SEC. 6.8: PRESCRIPTION DRUG LIMITATIONS

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

- erectile dysfunction tablets - such as Caverject®, Edex®, Muse®, Levitra® (with regard to Levitra®, see Sec. 6.4, Prescription Drug Prior Authorizations "phosphodiesterase inhibitor") and Cialis®(except for Cialis®when prescribed for once daily use of 2.3 mg or 5 mg dose for the treatment of benign prostatic hypertrophy, see Sec. 6.4, Prescription Drug Prior Authorizations) at a quantity limit of six every 34 days at retail and 20 every 90 days at retail (90) and mail service, regardless of strength;
- influenza treatment and preventions - such as Relenza® tablets, Tamiflu® 75 mg tablets and Tamiflu® suspension at a treatment quantity of one every six months at retail (90) and mail service;
- smoking cessation - For those covered under the MCTWF Retirees Plan, a maximum continuous drug therapy for any prescription drug is limited to coverage for 180 Days per a 12 month period and a lifetime maximum of two Years of therapy; and MCTWF Actives Plan health benefit packages are non-grandfathered and in compliance. For those covered under the MCTWF Actives Plan, the number of covered, appropriate, in-network counseling sessions for those diagnosed with tobacco use disorder is unlimited. Coverage for FDA approved,

physician prescribed tobacco cessation medications purchased from an in-network pharmacy fall into two categories, Nicotine Replacement Products (patch, gum, lozenges, Nicotrol inhalation system, and Nicotrol NS nasal spray) and Nicotine Deterrent Products (Chantix or Bupropion). No cost coverage for any physician prescribed product or combination of products in each category is limited to 168 days per calendar year.

- other limitations - Prostin VR® is Covered through age two, Elidel® is Covered for ages three and over and Protopic® is Covered for ages three and over.

SEC. 6.9: PRESCRIPTION DRUG REIMBURSEMENT

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

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

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

SEC. 6.10: PRESCRIPTION DRUG EXPENSES NOT COVERED

Your prescription drug benefit does not cover the following items:

- charges for any take-home drugs (for example, drugs brought home after out-patient surgery);
- any charges for therapeutic devices or appliances, regardless of their intended use;
- drugs or medicines supplied to the individual by a prescribing Physician or dentist;
- cosmetic or beauty aids, and diet supplements;
- immunizing agents, injectables, blood or blood plasma or medication prescribed for parenteral administration, except insulin and insulin syringes;
- existing and new drugs that are not uniformly and professionally endorsed by the general medical community for prescription in the course of standard medical care, including existing and new drugs that are Experimental in nature or any drug labeled "Caution: Limited by Federal Law to Investigational Use";
- any charge for administration of Covered drugs;
- any charge for prescription refills greater than the number of refills specified by your Physician or dentist, or any refill dispensed after one year from the date of the original prescription;
- the charge for any medication You are entitled to receive without charge from any municipal, state or federal program, whether contributory or not, except for Medicaid;
- medications that are not FDA-approved and that have not been proven effective for the conditions for which they are being used;

- charges for a Brand Name Selective Serotonin Reuptake Inhibitor (SSRI) prescription drugs without first satisfying the SSRI step therapy requirement;
- charges for non-sedating antihistamine prescription drugs without first receiving prior authorization;
- charges for proton pump inhibitor prescription drugs without first receiving prior authorization;
- charges for medications listed in Sec. 6.4, Prescription Drug Prior Authorizations, without first receiving prior authorization;
- charges for medications that exceed the limitations listed in Sec. 6.8, Prescription Drug Limitations;
- drugs that cost less than your Copayment;
- refills not authorized by a Physician;
- 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; and
- any expenses shown in General Exclusions and Limitations listed in Part 1.

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

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

Important Notice from the Michigan Conference of Teamsters Welfare Fund (The Fund) 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 the Fund and about your options under Medicare’s prescription drug coverage. This information can help You decide whether or not You want to join a Medicare 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 Participants, are expected to pay out as much as standard Medicare prescription drug coverage pays and therefore are considered Creditable Coverage. Because your existing coverage is Creditable Coverage,

You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare drug plan.

You can join a Medicare drug plan when You first become eligible for Medicare and each year from October 15th through December 7th. However, if You lose your current creditable prescription drug coverage, through no fault of your own, You will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If You decide to join a Medicare drug plan, under MCTWF rules You nonetheless may not drop your Fund prescription drug coverage. If You have both Fund prescription drug coverage and Medicare prescription drug coverage, the Fund prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If You are a COBRA Beneficiary You may drop your Fund coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, You will not be eligible to get your Fund COBRA coverage back later. If You do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug plan coverage. You should compare your current coverage, including which drugs are Covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to prior authorization requirements for certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs (effective January 1, 2016), non-sedating antihistamines (until December 31, 2015, thereafter not covered), proton pump inhibitors (after a 90 day generic supply during 365 day period or if brand is requested, effective January 1, 2016), selective serotonin reuptake inhibitors (brand name only), anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs with both retail and mail order availability, subject to Generic and Brand copayments, as detailed in your Summary Plan Description. Booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and You still will be eligible to receive all of your current health and prescription drug benefits if You choose to enroll in a Medicare prescription drug plan.

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

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

Contact 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...

Detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from

Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage -

- visit www.medicare.gov;
- call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help; or
- call (800)MEDICARE (800-633-4227). TTY users should call (877)486-2048.

If You have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at www.socialsecurity.gov, or You can call them at (800)772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage Notice. If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this notice when You join to show whether or not You have maintained creditable coverage and, therefore, whether or not You are not required to pay a higher premium (a penalty).

This notice also is sent out annually through the MCTWF Messenger newsletter.

SEC. 7.1: CHOICE OF DENTAL PROVIDERS

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

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

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

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

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

SEC. 7.2: PREDETERMINATION OF BENEFITS

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

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

7.2(a) OBTAINING A PREDETERMINATION OF BENEFITS

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

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

SEC. 7.3: ALTERNATE PROCEDURES

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

SEC. 7.4: COVERED DENTAL EXPENSES

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.

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

Class I - diagnostic and preventive services.

Class II - basic restorative services.

Class III - major restorative services.

Class IV - orthodontic services.

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

Class I Covered dental services include -

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

Class II Covered dental services and supplies include -

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

Class III Covered dental services and supplies include -

- onlays, crowns, bridgework, dentures and other prosthetics;
- relines or complete replacement of denture base material once in any three-year period per appliance;

- implants; and
- certain bone graft procedures in conjunction with implants.

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

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

Dental Occlusal Guard Benefit Limitations

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.

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

The MCTWF Actives Plan and MCTWF Retirees Plan includes expanded preventive services (four teeth cleanings and two fluoride applications per calendar year in part) for covered individuals with certain high-risk medical conditions.

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

- hypertrophic cardiomyopathy;
- pulmonary shunts or conduits; or
- mitral valve prolapse with regurgitation (blood leakage).

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

Periodontal Maintenance Coverage

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 periodontal maintenance services. Whether alone or in combination, coverage is limited to two such services per calendar year.

7.4(b) COVERED DENTAL EXPENSES AFTER ELIGIBILITY CEASES

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

- the completion of dentures (full or partial) if the impression was made prior to the loss of eligibility;
- the completion of fixed bridgework, restorations and crowns if the tooth or teeth were prepared prior to the loss of eligibility; and
- the completion of root canal therapy if the tooth or teeth were opened for treatment prior to the loss of eligibility.

Dental claims for these services initially will be denied. To have the claim reconsidered, the dentist then must resubmit the claim with a copy of your chart to document that the date the treatment commenced was prior to the loss of your eligibility.

7.4(c) OUT-OF-NETWORK SERVICES

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

SEC. 7.5: IF YOU DO NOT HAVE ACCESS TO NETWORK GENERAL DENTISTS OR ORTHODONTIC PROVIDERS

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

Similarly, in the event You live further than 25 driving miles (as determined by the Fund) from a Network orthodontist, You will have the option of seeking care from an orthodontist of your choice. To do so, You must apply for an exemption to use an Out-of-Network provider.

To obtain such exemption, You must apply utilizing a *Non-Access Exemption Application*. Authorization to use an Out-of-Network provider will be determined on a per application basis and will continue for the length of the treatment.

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

7.5(a) NON-ACCESS EXEMPTION APPLICATION

To be accepted, your application must be received by the Fund within 60 Days following the receipt of Out-of-Network services. If your application is approved, the claim will be deemed as Out-of-Network and all applicable Coinsurance and benefit maximum amounts will apply. Once your application to use an Out-of-Network general dentist is approved, the approval will continue for six months from the date that the first Out-of-Network services are rendered. In the case of orthodontic services, that approval will continue through the length of treatment. Any services beyond the treatment period must be authorized pursuant to the submission and approval of a new application. You may obtain a *Non-Access Exemption Application*, by calling the Fund's Member Services Call Center or from the Fund's website.

SEC. 7.6: DENTAL EXPENSES NOT COVERED

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

- appliances, restorations or services for the diagnosis or treatment of temporomandibular joint dysfunction (TMJ). This may be Covered under your MCTWF Actives and MCTWF Retirees Plan medical benefits;
- treatment given by anyone who is not a licensed dentist or dental practitioner, except charges for dental prophylaxis performed by a dental hygienist under the supervision and direction of a dentist;
- temporary restoration;
- charges for sealants, except for first and second permanent molars of Dependent children up to age 15 with high risk teeth and with prior authorization. High risk means teeth which have caries (tooth decay) in one or more molars;
- repair or reapplication of sealants for Dependent children within three Years from the sealant application date;
- charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control;
- procedures, services or supplies that are Experimental in nature;
- procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, or for increasing vertical dimension, splinting or replacing tooth structure lost as the result of abrasion or attrition;
- drugs, medicaments, prescriptions, other than the injection of antibiotics;
- inlays;
- charges made by a Hospital;
- expenses for root canal treatment and/or apicoectomies when previously paid;
- expenses for services or appliances started before the effective date of coverage under your MCTWF Actives Plan and MCTWF Retirees Plan;
- expenses for replacement made less than five Years after placement or replacement that was Covered by the MCTWF Actives Plan or MCTWF Retirees Plan including crowns, onlays,

- substructures (including pins, posts, cores and thimbles), fixed bridges, implants, removable prosthetic appliances and occlusal adjustment;
- limited occlusal adjustment not more than three times in a five year period;
- general anesthesia, intravenous sedation, and/or non-intravenous conscious sedation, for restorative dentistry or for surgical procedures, unless Medically Necessary;
- benefits or services that are available from any government agency, political subdivision, community agency, foundation, mutual benefit association, labor Union trust or similar group or any similar entity;
- expenses for extension of bridges or prosthetic devices previously paid for by the MCTWF Actives Plan or MCTWF Retirees Plan incurred in new extended areas;
- orthodontic expenses for those over age 19, if provided by an Out-of-Network provider. (In-network coverage covers all children and adults).
- orthodontic expenses for Participants and Spouses under age 19, if provided by an Out-of-Network provider;
- services or supplies received as a result of dental disease or injury due to an act of war, declared or undeclared;
- expenses for mouth guards and associated devices;
- services as determined by the Fund for cosmetic surgery or dentistry for aesthetic reasons;
- any expenses incurred that exceed the dental/orthodontia services Annual and/or lifetime maximums;
- porcelain, porcelain substrate, and cast restorations for Dependent children less than 12 years of age;
- fixed bridges and removable cast partials for Dependent children less than 16 years of age;
- oral examination, prophylaxis (cleaning) more than two times per calendar year, except for high risk medical conditions (see Sec. 7.4(a), Covered Dental Expenses for High Risk Medical Conditions);
- bitewing x-rays more than two times per calendar year;
- full mouth or panoramic x-rays more than once in a five year period per dental specialty, except when there is adequate evidence that an additional x-ray is clinically necessary;
- fluoride treatments for Dependents up to age 14 more than two times per calendar year;
- fluoride treatment for Dependents age 14 and over;
- relin or complete replacement of denture base material more than once in any three-year period per appliance;
- cosmetic services including teeth whitening; or
- all porcelain composition crowns seated in the posterior portion of the mouth.
- dental services or supplies as determined by Delta Dental, for which no valid dental need can be demonstrated, or that are investigational in nature (including service or supplies required to treat complications from investigational procedure), or that are a specialized technique, or that are not provided in accordance with generally accepted standards of dental practice.
- dental services for dependent children if covered under the MCTWF Retirees Plan.

SEC. 8.1: CHOICE OF VISION PROVIDERS

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

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

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

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

SEC. 8.2: IN-NETWORK OPTION

The in-network option provides You coverage as follows:

EyeMed Vision Care is MCTWF's vision benefits administrator. MCTWF has contracted with it for access to its broad Insight Network. You have received notifications from MCTWF and from EyeMed 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). 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. 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 online eyeglass options through 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 online contact lens options through 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 there for in-network laser vision correction providers). Both sites price their products in accordance with the MCTWF vision benefit and provide free shipping.

The MCTWF Actives Plan or MCTWF Retirees Plan pays for one exam and one vision correction option per person per calendar year. Benefits based on a per lifetime limit for laser vision correction and a calendar year limit for all other vision options. A vision option is defined either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.

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 or link to it through our website at www.mctwf.org, under the Info Links tab.

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.

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

SEC. 8.3: OUT-OF-NETWORK OPTION

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

SEC. 8.4: VISION EXPENSES NOT COVERED

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

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

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

SEC. 9.1: EMPLOYEE DEATH BENEFIT

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

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

SEC. 9.2: BENEFICIARY DEATH BENEFIT

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

SEC. 9.3: HOW YOUR PLAN PAYS BENEFITS

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

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

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

If You don't name a beneficiary or if You have no surviving beneficiary, benefits will be paid to your estate. You are automatically designated as the beneficiary for your Spouse and Dependent children.

Accidental death and dismemberment (AD&D) benefits are paid if the Participant dies or is seriously injured as a result of an Accident. AD&D benefits may be paid in addition to Active death benefits, but not in addition to Retiree Death Benefit Program benefits.

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

Event Benefit	Benefit	Who Receives
If Participant dies	100% of benefit maximum	Participant's Beneficiary
Participant's loss of both hands or feet	100% of benefit maximum	Participant
Participant's loss of the sight of both eyes	100% of benefit maximum	Participant
Participant's loss of one hand and one foot	100% of benefit maximum	Participant
Participant's loss of one hand and the sight of one eye	100% of benefit maximum	Participant
Participant's loss of one hand or one foot	50% of benefit maximum	Participant
Participant's loss of the sight of one eye	50% of benefit maximum	Participant

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

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

SEC. 10.1: WHEN BENEFITS ARE NOT PAYABLE

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

- Illness, whether physical or mental, or medical or surgical treatment;
- ptomaine, or bacterial infections, except infection caused by a visible wound resulting from an Accidental Injury or Illness;
- suicide while sane or insane, or any intentionally self-inflicted Accidental Injury or Illness;
- death as the result of the deceased Participant's impaired conduct, of whatever nature, caused by the voluntary or involuntary use of alcohol beyond the legal limit for operation of a motor vehicle, or misuse of drugs;
- war, or any act of war, whether declared or undeclared;
- an insurrection or participation in a riot;
- commission of a crime; or
- losses occurring 90 Days beyond the date of the Accidental Injury that resulted in the loss.

The Retiree Death Benefit provides death benefits for MCTWF Retirees Plan Retirees and their Spouses. Eligible Retirees and their Spouses individually may choose the amount of death benefit each wishes to have, from \$1,000 up to \$10,000.

SEC. 11.1: HOW THE PROGRAM PAYS BENEFITS

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

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

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

SEC. 11.2: TERMINATION OF COVERAGE

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

- date the Retiree dies, or, for Spouse coverage, the date the Spouse dies;
- failure to file a Contribution within the time required; or
- the date of termination of the Retiree Death Benefit Program as determined by the Trustees or an amendment to the Retiree Death Benefit Program eligibility requirements by the Trustees that make the Retiree or Spouse no longer eligible for coverage under the Retiree Death Benefit Program.

The Flexible Dependent Coverage benefit provides a health reimbursement account to cover certain medical, dental and vision expenses for You that are not reimbursed by the Fund or other group health plans and that are deductible from an individual tax return if itemized (pursuant to section 213(d) of the Internal Revenue Code).

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

SEC. 12.1: HEALTH REIMBURSEMENT ACCOUNT CREDITS

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

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

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

Eligible expenses are -

- abortion;
- acupuncture;
- alcoholism treatment;
- ambulance service;
- artificial limbs;
- artificial teeth;
- birth control pills;
- Braille books and magazines;
- breast reconstruction surgery following mastectomy;
- mastectomy bras that exceed the two allowable per calendar year;
- capital expenses for home medical equipment or improvements for medical care;
- car controls and equipment for disabled persons;
- chiropractic care;
- Christian Science Practitioner;
- contact lenses;
- Contribution copayments for an MCTWF Actives Plan that are paid on a post-tax basis;
- Copayments and Deductibles paid under the MCTWF Actives Plan;
- crutches;
- dental treatment;
- diagnostic tests;
- diagnostic imaging;

- disabled Dependent care;
- Doctor's fees;
- duplicate prosthetic devices;
- drug addiction inpatient treatment;
- drugs requiring a prescription;
- eyeglasses;
- eye surgery;
- fertility enhancement;
- guide dogs or other service animal;
- health institute treatment prescribed by a Physician;
- hearing aids and examinations;
- hearing treatment;
- Hospital services;
- insulin;
- lab fees;
- lead based paint removal, when child has lead poisoning;
- learning disability tuition;
- legal fees necessary to authorize treatment for mental illness;
- legal fees associated with procuring an egg donor for the direct purpose of correcting infertility;
- lifetime care (i.e., advance payments ensuring lifetime care in a retirement home, medical portion);
- lodging in Hospital or similar institution while receiving care;
- long-term care premiums and unreimbursed expenses;
- meals at Hospital or similar institution while receiving inpatient care;
- medical equipment, supplies, or diagnostic devices to the extent that such items mitigate the effect of an Accidental Injury or Illness or assist in the treatment of the Accidental Injury or Illness (with or without a prescription);
- medical services;
- medicines prescribed by a Physician;
- mentally retarded, special home;
- nursing home services (Medically Necessary);
- nursing services;
- operations (i.e. medical expenses You pay for operations that are not medically unnecessary cosmetic surgeries);
- optometrist's fees;
- organ transplants;
- osteopath;
- oxygen;
- periodontal fees;
- prostheses;
- psychiatric care;
- psychoanalysis;
- psychologist;
- psychotherapy (by approved provider);
- special schools for the handicapped;
- sterilization (i.e., legally performed surgery for the purpose of making a person unable to have children);
- smoking cessation programs (does not include non-prescription drugs such as nicotine gum and patch);

- surgery;
- telephone for the deaf;
- television equipment for hearing impaired;
- therapy received as medical treatment;
- transplant donor expenses;
- transportation for medical care;
- tuition (i.e., medical expense charges for medical care included in tuition of a college/private school);
- vasectomy;
- vitamins requiring a prescription;
- vision correction surgery (such as LASIK or radial keratotomy);
- weight-loss program - if prescribed by Physician with respect to specific disease (includes group fees; does not include dues for gym, health club, or spa; does not include diet food or beverage unless food does not satisfy normal nutritional needs, food alleviates or treats an illness, and need for the food is substantiated by a Physician);
- wheelchair or autoette; and
- wig purchased upon the advice of a Physician.

12.1(b) EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses not eligible for your reimbursement account include but are not limited to -

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

SEC. 12.2: REIMBURSEMENT PROCEDURES

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

Reimbursement from your account can be made up to twice yearly depending upon whether You choose to make semi-annual or Annual submissions for reimbursement, as follows:

- in order to qualify for reimbursement of eligible expenses incurred (i.e., paid for) between January and June, You may submit them between July 1st and August 31st of that year; and/or
- for reimbursement of expenses incurred between July and December or throughout the entire calendar year, You may submit them between January 1st and March 31st of the following year or, if You are submitting them for the first time for the prior year, You may submit them between January 1st and May 31st.

Reimbursement is based upon the date You pay for the services and not on the date of the service. For example, if service was rendered to You in December 2020 but it was not paid for until January 2021, the expense is considered an eligible expense for the year 2021 under the MCTWF Actives Plan.

When You request reimbursement from your account, You must submit a *Flexible Dependent Coverage Benefit Claim Form* along with your paid receipts, rejections or proof that the other group health plan has paid its maximum benefits. All receipts must reflect payment in full, must contain a written description of the service/expense, must be a qualified service/expense and must not be an expense reimbursable by another policy or Plan. You may call the Fund's Member Services Call Center for additional *Flexible Dependent Coverage Benefit Claim Forms*, or obtain one from the Fund's website.

Sums credited to your account may be used only for expenses that You incur during periods in which You -

- are eligible under your MCTWF Actives Plan; and
- participate in the Flexible Dependent Coverage benefit.

Sums credited to your account will be forfeited if reimbursement is not requested before April 1st of the year following the year in which You incurred the eligible expenses.

If You use Network providers, they will file claims and will be paid pursuant to contract. If your Out-of-Network provider requests a claim form, it is available by calling the Fund's Member Services Call Center or from the *Forms* page of the Fund's website. To check on the status of your claim, You may contact the Fund's Member Services Call Center or through the Fund's Participant Web Portal.

SEC. 13.1: CLAIMS FOR MEDICAL BENEFITS

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

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

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

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

You must notify the Fund when you return to work. If you receive benefits for any period beyond your return to work that you are not entitled to, you will be responsible for reimbursement to the Fund of those overpaid benefits.

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

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

SEC. 13.4: CLAIMS FOR PRESCRIPTION DRUG BENEFITS

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

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

Prescription filled prior to establishing COBRA continuation coverage.	Reimburse the amount determined by CVS/Caremark to be appropriate, less the applicable co-payment.
Prescription filled that is rejected by CVS/Caremark, but is subsequently approved pursuant to Fund's Medical Director review.	Reimburse the amount determined by CVS/Caremark to be appropriate, less the applicable co-the payment.
Compound prescription filled that is rejected by CVS/Caremark and subsequently approved pursuant to CVS/Caremark review.	Reimburse the amount determined by CVS/Caremark to be appropriate, less the applicable copayment.
Prescription filled at a non-participating (Out-of-Network) pharmacy.	Reimburse the amount determined by CVS/Caremark to be appropriate, less the applicable co-payment.

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

SEC. 13.5: CLAIMS FOR DENTAL BENEFITS

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

SEC. 13.6: CLAIMS FOR VISION BENEFITS

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

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

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

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

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.

SEC. 13.8: CLAIM RECEIPT DEADLINE

All claims for benefits must be received within fifteen months after the date the eligible expense is incurred (i.e. date the services were rendered) except that claims for weekly accident and sickness benefits and total and permanent disability benefits must be received within fifteen months after the Disability occurs, three years following the active Participant or Beneficiary and the Retiree or Retiree Spouse date of death or the Participant's date of accidental death and dismemberment. If the Fund requests additional information from You or your provider with regard to your claim, the Fund must receive the response within 45 Days from the date of the request to respond

The 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 the 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.

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 or by contacting MCTWF's Member Services Call Center at (800) 572-7687.

The Fund's Board of Trustees has full and absolute discretion, authority and power to interpret the terms of the MCTWF's Actives Plan and MCTWF Retirees Plan, determine all questions of coverage and eligibility and adjudicate benefit claims. If your benefit claim is denied in whole or in part, You have the right to appeal.

SEC. 14.1 APPEAL PROCEDURE FOR MCTWF ACTIVES PLAN

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

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

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

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

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

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

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

Other resources to help You: For help about your rights, this notice, or for assistance, You can contact: the Employee Benefits Security Administration (EBSA) at (866) 487-2365.

Additionally, a consumer assistance program can help You file your appeal. Contact the by mail at Department of Insurance and Financial Services (DIFS) at P.O. Box 30220, Lansing, MI 48909-7720, by phone at (877) 999-6442, or email DIFSInfo@michigan.gov.

SEC. 14.2 APPEAL PROCEDURE FOR MCTWF RETIREES PLAN

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

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

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

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

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

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

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

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

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

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

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

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

- state specific reason(s) for the adverse determination;
- refer to specific MCTWF Plan provision(s) on which the benefit determination is based;
- state that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request), if the denial is based on a Medical Necessity or Experimental treatment or similar limit; and
- include a statement regarding your right to commence a legal action under section 502(a) of under the Employee Retirement Income Security Act of 1974 (ERISA).

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

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

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 or benefits are otherwise paid in excess of what the plan provides. MCTWF has the right and obligation to recover such overpayments from:

- any person to whom payments were made;
- any person for whom payments were made,
- any insurance company, healthcare provider, or other organization to which 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.

SEC. 16.1: ASSIGNMENT, SUBROGATION AND REIMBURSEMENT - MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

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, in connection with a motor vehicle, or any other Accidental Injury or illness caused in whole or in part by third parties. Claims are reviewed 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.

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.

When the Fund pays any benefits for You, it immediately gains all rights of recovery against any person or entity that caused or contributed to the loss. This is called subrogation. Where reasonable cause exists to believe there may be another source from which to recover for the same loss, payment of benefits is conditioned upon the execution by You of the Fund's *Assignment, Subrogation and Reimbursement Agreement*.

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

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

You and those acting on your behalf, including attorneys –

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

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

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

The Fund is entitled to assignment, subrogation and reimbursement even if such amounts constitute only a partial recovery and are insufficient to compensate You for all damages sustained. The Fund is not required to participate in any damage claim or pay attorney's fees to any attorney You hire to pursue the damage claim. This assignment, subrogation and reimbursement provision applies whether or not a third party admits liability for payment.

You may receive payment for medical services before benefits are paid under the Fund. In that case, the benefit payable by the Fund will be limited to the amount of benefits in excess of the amount already paid, if any. Such amounts include all direct or indirect payments to, or on behalf of, You for Accidental Injury or Illness from any source by settlement, judgment or any other means.

Work Related Injury/Illness – Conditional Coverage

Under MCTWF's General Exclusions and Limitations listed in your Summary Plan Description it states in part that an Accidental Injury or Illness arising in the course of employment is not covered.

You may be eligible to receive benefits under an Assignment, Subrogation and Reimbursement Agreement if your workers' compensation claim is denied and You are pursuing the claim through the applicable governmental agency for payment of all available benefits, upon compliance with all the requirements of the Assignment, Subrogation and Reimbursement Agreement. All requests are reviewed on an individual basis. However, if your Beneficiary suffers a work related Accidental Injury or Illness and has other insurance, which is primary to your MCTWF Actives Plan or MCTWF Retirees Plan, no Assignment, Subrogation and Reimbursement Agreement will be offered.

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 claims incurred pre-settlement continue to be deemed work-related, claims incurred post-settlement are deemed non-work related and are eligible for payment if the individual is actively covered with a MCTWF benefit package. If settlement is by way of a "voluntary payment agreement" (or similar instrument by which future claims are left open), not only do claims incurred pre-settlement continue to be deemed work related, claims incurred post-settlement 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.

In the event a Workers Compensation claim is deemed non-compensable by decision of the applicable governmental agency or any appeal thereof the Fund's work related exclusion would no longer apply, retroactive to the date of the said Accidental Injury or Illness.

An individual who is entitled to receive benefits under an MCTWF Actives Plan and MCTWF Retirees Plan may also be eligible for similar benefits under another group health plan.

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

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

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

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

SEC. 17.1: COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

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

If the patient's Primary Plan reduces benefits because of non-compliance with its specific provisions, the amount of that reduction will not be Covered under the MCTWF Actives Plan and MCTWF Retirees Plan. For instance, a patient may fail to request prior authorization as required under the patient's Primary Plan. If the patient then pays a penalty in the form of an additional Deductible because of non-compliance, that penalty will not be paid by the MCTWF Actives Plan or MCTWF Retirees Plan.

SEC. 17.2: COORDINATION WITH MEDICARE

Medicare provides coverage to people who -

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

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

In the case of MCTWF Actives Plan participation -

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

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

In the case of COBRA continuation coverage Plan participation -

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

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

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

SEC. 17.3: RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To the extent permitted by law, the Fund reserves the right to release or obtain any information about You to or from any insurance company, Hospital, Physician or other organization or individual to determine how benefits will be paid. In addition, if You are claiming benefits under the MCTWF Actives Plan or MCTWF Retirees Plan, You will be required to provide any necessary information to the Fund.

Your benefits under the MCTWF Actives Plan or MCTWF Retirees Plan may not be assigned by the Fund or seized to pay your debts unless -

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

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

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that You are entitled to:

SEC. 19.1: RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

The Employee Retirement Income Security Act (ERISA) requires the following:

You have the right to -

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and Union halls, all documents governing the MCTWF Actives Plan and MCTWF Retirees Plan. These include insurance contracts and Collective Bargaining Agreements, and a copy of the latest Annual report (Form 5500 Series) filed by the MCTWF Actives Plan and MCTWF Retirees Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the MCTWF Actives Plan and MCTWF Retirees Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest Annual report (Form 5500 Series) and updated SPD Booklet. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the MCTWF Actives Plan and MCTWF Retirees Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.

SEC. 19.2: CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to -

- Continue health care coverage for yourself if there is a loss of coverage under the MCTWF Actives Plan or MCTWF Retirees Plan as a result of a qualifying event. You may have to pay for such coverage. Review this SPD Booklet and the documents governing the MCTWF Actives Plan and MCTWF Retirees Plan on the rules governing your COBRA continuation coverage rights.
- You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when -
 - You lose coverage under your MCTWF Plan;
 - You become entitled to elect COBRA continuation coverage; or
 - your COBRA continuation coverage ceases.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage.

SEC. 19.3: PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for You, ERISA imposes duties upon the people who are responsible for the operation of the MCTWF Actives Plan and MCTWF Retirees Plan. The people who operate the MCTWF Actives Plan and MCTWF Retirees Plan, called "fiduciaries" of the MCTWF Actives Plan and MCTWF Retirees Plan, have a duty to do so prudently and in the interest of You and other MCTWF Actives Plan and MCTWF Retirees Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising your rights under ERISA.

SEC. 19.4: ENFORCE YOUR RIGHTS

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

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

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

SEC. 19.5: ASSISTANCE WITH YOUR QUESTIONS

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

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

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

You may also find answers to the MCTWF Actives Plan and MCTWF Retirees Plan questions at the website of the EBSA at <https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices>.

The following material provides information about how the MCTWF Actives Plan and MCTWF Retirees Plan are administered:

The following material provides information about how the MCTWF Actives Plan and MCTWF Retirees Plan are administered:

SEC. 20.1: PLANS' NAME AND ADDRESS

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

SEC. 20.2: PLANS' SPONSOR

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

SEC. 20.3: PLANS' EMPLOYER IDENTIFICATION NUMBER (EIN)

38-1328578

SEC. 20.4: PLANS' NUMBERS

501 - MCTWF Actives Plan
502 - MCTWF Retirees Plan

SEC. 20.5: TYPES OF WELFARE PLANS

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

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

SEC. 20.6: TYPE OF PLAN ADMINISTRATION

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

SEC. 20.7: PLANS' ADMINISTRATOR

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

SEC. 20.8: PLANS' TRUSTEES

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

Union Trustees:

Kevin D. Moore
Gregory W. Nowak
Ellis P. Wood
Thomas A. Ziembovic

Employer Trustees:

Raymond J. Burratto
Earl D. Ishbia
Robert W. Jones
Ann R. Zick

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

SEC. 20.9: COLLECTIVE BARGAINING AGREEMENTS

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

SEC. 20.10: SOURCES OF CONTRIBUTIONS TO THE PLANS

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

SEC. 20.11: FUNDING

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

SEC. 20.12: PLANS' YEAR

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

SEC. 20.13: AGENT FOR SERVICE OF LEGAL PROCESS

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

SEC. 20.14: ADMINISTRATIVE SERVICES

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

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

Delta Dental of Michigan
4100 Okemos Road
Okemos, Michigan 48864

CVS/Caremark
2211 Sanders Road
Northbrook, Illinois 60062

EyeMed Vision Care
4000 Luxottica Pl.
Mason, OH 45040

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

20.14(a) EMPLOYMENT RIGHTS NOT GUARANTEED

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

20.14(b) AMENDMENT OR TERMINATION OF PLANS

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

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

**20.14(c) MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND
TERMINATION**

The Michigan Conference of Teamsters Welfare Fund may be terminated at any time and for any reason. In such event, the Trustees will take necessary steps to wind down the Trust. In conformity with the provisions of the Trust Agreement, the Trustees will apply the MCTWF Actives Plan and MCTWF Retirees Plan assets to pay or to provide for the payment of all obligations of the MCTWF Actives Plan and MCTWF Retirees Plan respectively. Any remaining MCTWF Actives Plan and MCTWF Retirees Plan surplus will, in accordance with the terms of the Trust Agreement, be used in such manner as the Trustees believe will best effectuate the purpose of the Trust, subject to the requirement that no part of the assets of the Trust be diverted to any purpose other than the exclusive benefit of Participants and Beneficiaries and payment of the administrative expenses of the MCTWF Actives Plan and MCTWF Retirees Plan, respectively. Upon termination, no part of the assets of MCTWF Actives Plan and MCTWF Retirees Plan, respectively, will revert or accrue, directly or indirectly, to the benefit of an Employer or the Union.

The Trustees have the full and absolute discretion, authority and power to interpret, control and implement the terms and provisions of all documents and instruments governing the Michigan Conference of Teamsters Welfare Fund including, but not limited to, the terms of the MCTWF Actives Plan and MCTWF Retirees Plan benefits, rules, regulations and policies adopted by the Trustees, or to alter, amend or terminate the MCTWF Actives Plan or MCTWF Retirees Plan.

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

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

Benefits under the MCTWF Actives Plan or MCTWF Retirees Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

SEC. 21.1: COVID-19 RELATED COMMUNICATIONS DURING 2020

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 (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.55mctwf.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.

SEC. 21.2: COBRA CONTINUATION COVERAGE NOTICE

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 (COVID19) 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 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.

SEC. 21.3: 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:

- 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 29CFR 2560.503- 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).

SEC. 21.4: COVID-19 At-Home Testing Coverage

In January 2022, the federal government issued new requirements for group health plans to provide coverage 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. Two coverage options are available to You and MCTWF eligible dependents to obtain the OTC at-home COVID-19 tests as described:

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 available 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 claim.

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.mctwf.org.

Coverage details for both coverage options:

- At-Home Testing coverage is for home use only and is not for employment purposes.
- Allows for the reimbursement of up to 8 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. Questions? 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.

The Health Insurance Portability and Accountability Act (HIPAA) is a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also gives the Federal Government the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and Employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

The Fund's HIPAA privacy, security and enforcement regulations, which are pursuant to Regulations by the U.S. Department of Health and Human Services are designed to provide You with guaranteed protection and security of your health care information – information that your Doctor, Hospital, pharmacist and other health care provider might have regarding your medical condition and treatments You receive from them. The Privacy Rules (as outlined in the Notice of Privacy Practices) also affect how the Fund operates on your behalf as well. As required by the Health Insurance Portability and Accountability Act (HIPAA), the following is the HIPAA Notice of Privacy Practices, which also can be found on the HIPAA Privacy Rule page of MCTWF's website at www.mctwf.org: "Notice of Privacy Practices for Protected Health Information, Your Information, Your Rights, Our Responsibilities."

SEC. 22.1: NOTICE OF PRIVACY PRACTICES

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

Your Rights

You have the right to:

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

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Other 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

SEC. 22.1(a) YOUR RIGHTS

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

Get a Copy of Health and Claims Records

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

Ask us to Correct Health and Claims Records

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

Request Confidential Communications

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

Ask us to Limit what we Use or Share

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

Get a List of those with Whom We’ve Shared Information

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

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 a Personal Representative

- 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 directly or using the *Complaint Form* on the HIPAA Privacy Rule page at www.mctwf.org.
- 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 (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against You for filing a complaint.

22.1(b) YOUR CHOICES

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

In these cases, You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If You are not able to tell us your preference, for example if You are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless You give us written permission:

- Marketing purposes
- Sale of your information

22.1(c) OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help Manage the Health Care Treatment You Receive

We can use your health information and share it with professionals who are treating You.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our Organization

- We can use and disclose your information to run our organization and contact You when necessary.
- We are not allowed to use genetic information to decide whether we will give You coverage and the price of that coverage. 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/hipaa/for-individuals/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 are complying with federal privacy law.

Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director

- We can share health information about You with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests

- We can use or share health information about You:
 - For workers' compensation claims.
 - For law enforcement purposes or with a law enforcement official.
 - With health oversight agencies for activities authorized by law.
 - For special government functions such as military, national security, and presidential protective services.

Respond to Lawsuits and Legal Actions

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.

22.1(d) OUR RESPONSIBILITIES

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

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

22.1(e) CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about You. The new notice will be available upon request, on our web site, and we will mail a copy to You.

This Notice is effective April 2022

Privacy Officer: Gail Wilson

(313) 964-2400 ext. 202

privacyofficer@mctwf.org

The following are definitions of specific words and terms used in this SPD Booklet:

Accident means an unexpected or unintentional occurrence.

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

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

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

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

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

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

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

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

Beneficiary means a person who is -

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

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

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

Collective Bargaining Agreement means the negotiated labor agreement between your bargaining representative and your Employer.

Copayment means the flat dollar amount You are responsible for paying when You receive medical services or obtain prescription drugs and may depend on whether services are provided by a Network or Out-of-Network provider.

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

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

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

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

Days means calendar Days unless stated as business days.

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

Dependent means a person who is -

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

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

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

Durable Medical Equipment is equipment that -

- can withstand repeated use;
- is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Accidental Injury or Illness; and
- is not disposable or non-durable

Employee means a person for whom an Employer is obligated to make Contributions to the Fund under a Collective Bargaining Agreement or Fund Participation Agreement

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

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

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

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

Fund means the Michigan Conference of Teamsters Welfare Fund.

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

Hospital means an institution that -

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

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

Local Union means those Local Unions affiliated with the International Brotherhood of Teamsters.

Maximum Allowable Benefit (MAB) means the MCTWF Actives Plan and MCTWF Retirees Plan's allowable portion of the Amount Billed by a provider that does not participate in the BCBS, Delta Dental of Michigan or EyeMed Vision, subject to Deductible, Copayment and Coinsurance amounts.

MCTWF means the Michigan Conference of Teamsters Welfare Fund.

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

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

Medically Necessary means those services, treatments or supplies provided to You by a Hospital or healthcare professional, which services are required, in the judgment of the Trustees, to identify or treat a condition, disease, Accidental Injury or Illness and -

- are consistent with the symptoms, diagnosis or treatment of the condition, disease, Accidental Injury or Illness;
- are appropriate according to acceptable standards of good medical practice;
- are not solely for the convenience of You, the Hospital or the healthcare professional;
- are the most appropriate that can be safely provided to You under the circumstances; and
- are not Experimental or Investigative in nature.

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

Member means participant, or other eligible beneficiaries covered under the Participant's plan.

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

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

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

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

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

Participant means Employee or Retiree.

Participation Agreement means a written agreement signed by an Employer pursuant to which the Employer contributes to the Fund.

Primary Plan means the Plan that pays benefits first when more than one group health plan provides coverage to You.

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

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

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

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

Seasonal Work means work that is performed only during certain seasons

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

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

Skilled Nursing Facility means an institution, or distinct part of an institution, that -

- has in effect a transfer agreement with one or more Hospitals;
- is primarily engaged in providing inpatient skilled nursing care;
- is duly licensed;
- has one or more Physicians and one or more registered professional nurses responsible for patient care;
- requires that patients be under the care of a Physician;
- maintains clinical records for all patients;
- provides 24-hour-a-day nursing services;
- provides procedures to dispense drugs and medications;
- has a utilization review plan in effect;
- is eligible to participate in Medicare; and
- is not an institution that primarily covers the care and treatment of mental diseases or tuberculosis.

Spouse means an individual recognized as a Spouse of the Participant under the law of any State of the United States.

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

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

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

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

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

Union means the International Brotherhood of Teamsters.

Year means a period of 365 Days.

You means the Participant and his eligible Beneficiaries.

NOTES:





**Michigan Conference of
Teamsters Welfare Fund**
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