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Compilation of Messenger Notifications
Summer 2022 through Winter-Spring 2024

The Messenger is a publication that is used to notify you of changes to your benefit package. Such notifications, in combination with your Summary Plan Description (SPD) booklet and Schedule of Benefits, form your complete SPD. The most recent SPD was issued in April of 2022 and then published and mailed to participants. Attached you will find a compilation of Messenger notifications from Summer 2022 through Winter-Spring 2024, arranged chronologically by topic. It is vital that you read all notifications within a topic to ensure that you are aware of the latest changes.

February 2024

Compilation of Messenger Notifications Summer 2022 through Winter-Spring 2024

Contents

INTRODUCTION – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

The most recent revision of the Summary Plan Description (SPD) booklet, dated April 2022, was mailed to all MCTWF Actives Plan and MCTWF Retirees Plan participant households. If the SPD booklet (and/or the subsequently mailed Schedule of Benefits) was not received, the Fund will mail it to you at your request. You also may access the SPD booklet and your Schedule of Benefits on the Fund's website at www.mctwf.org from the *Summary Plan Description* page. The SPD is scheduled for its next updated printing in the Fall of 2027. For all pandemic-related information published before July 2022, please refer to the 2022 edition of your SPD booklet.

PART 2: ELIGIBILITY - MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

Show Your Cards! (Fall 2022)
When MCTWF members receive healthcare services, it is imperative that they present their MCTWF ID cards to avoid any confusion regarding MCTWF benefits.

When receiving medical services, please show both the gold BCBSM ID card and the white MCTWF Networks card. When receiving vision, prescription drugs or dental services, members should show the white MCTWF Networks card.

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

The Importance of Opening MCTWF Mail and Cashing Checks on Time (Fall 2022)
Kudos go to the people who open every single piece of "snail mail" that comes to their door. However, not everyone is that dedicated. In these times where we receive so many marketing schemes and political ads in the mail, it may be hard to keep up.

The important thing to remember is that when MCTWF mail arrives, it's imperative to open it as soon as possible, especially when expecting a reimbursement.

At MCTWF, benefit payments are mailed out in check form and must be cashed within 60 days.

If a member attempts to cash a check from MCTWF that is already voided, he/she runs the risk of being charged a return deposit fee from his/her bank. MCTWF members can request a new check, but to save time, and avoid extra fees, please be sure to cash the check before the 60-day deadline.

Even if MCTWF mail does not contain a check, it is important to review the correspondence, and if appropriate, respond in a timely manner.

Reminder: Retiree Benefit Eligibility Ceases Upon Medicare Eligibility (Fall 2022)
In addition to the other causal events stated in your Summary Plan Description, MCTWF Retirees Plan eligibility ceases for a retiree or spouse as of the earlier of the first of the month in which the retiree's or spouse's 65th birthday falls or when he/she becomes eligible for Medicare Part A coverage. If you are a retiree or a retiree's spouse who is becoming (or has become) eligible for Medicare Part A coverage prior to your 65th birthday, it is imperative that you immediately inform MCTWF of your early Medicare eligibility date and that you cease the use of MCTWF Retirees Plan benefits. MCTWF will ask you for a copy of your Medicare card or letter from the Social Security Administration stating your effective eligibility date. MCTWF will pursue recovery from you for any benefits paid for services incurred on or after your Medicare eligibility date.

Family Status Updates and SPD Clarification (Winter 2022 – 2023)
Certain information concerning participants and their beneficiaries (i.e., spouse and eligible children) is essential to MCTWF's proper and accurate administration of the plan.

All MCTWF participants must provide all required documentation concerning themselves and all of their eligible beneficiaries to permit initial enrollment. It is necessary for participants to keep MCTWF informed of any change to their family status, including marriage, divorce, birth of child, child adoption, change of address, change of email address, change of phone number, or other insurance information (COB), etc.

Notification must occur immediately when such changes occur by submitting a Change in Family Status Form or a Contact Update Form. Both forms are available on the Forms page of the Fund's website.

Clarification
As stated in the Summary Plan Description (SPD): 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 90 days of that event, eligibility for retroactive coverage will begin on the date 90 days prior to the Fund's receipt of such notification.

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

IRS 1095-B Forms Are Mailed in February (Winter 2022 – 2023)
The required Internal Revenue Service (IRS) 1095-B forms are being mailed to eligible participants during the month of February.

Retiree Medical Benefit Package Rates for Plan Year April 2023 - March 2024 (Winter 2022 – 2023)
The standard and expanded eligibility monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical and prescription drug Benefit Package 145. For those purchasing Benefit Package 475 (which adds to the basic medical and prescription drug benefits the Retiree Supplemental Benefits Rider – Hearing, Vision, and Dental Plan 2 benefits), add $100.55 to Benefit Package 145 monthly rates.

April 2023 Retiree Medical Benefit Package 145 Standard Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	**5 – 9**	**10 – 14**	**15 – 19**	**20 – 24**	**25 – 29**	**30 +**
50 – 54	$750	$680	$620	$560	$480	$425
55 – 59	$585	$545	$505	$465	$430	$400
60 – 64	$425	$415	$400	$375	$370	$360
For eligible retirees whose active employment ceased prior to January 1, 2002: $360						

April 2023 Retiree Medical Benefit Package 145 Expanded Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	**5 – 9**	**10 – 14**	**15 – 19**	**20 – 24**	**25 – 29**	**30 +**
57 – 59	$645	$600	$555	$510	$475	$440
60 – 64	$465	$455	$440	$410	$405	$395

April 2023 Retiree Medical Benefit Package 145 Extended Retiree Spouse* Monthly Self-Contribution Rates (For Benefit Package 475, add $100.55)		
Age at Start of Each Plan Year	**Female**	**Male**
50 – 52	$593.65	$483.30
53 – 55	$647.70	$612.20
56 – 58	$672.30	$749.25
59 – 61	$696.10	$880.90
62 – 64	$735.70	$980.60

Increase in MCTWF Retirees Plan Calendar Year Benefit Limit

The MCTWF Retirees Plan health (medical and prescription drug) benefits calendar annual benefit limit, exclusive of Phase III Specified Organ Transplants, per covered individual, has been increased from $250,000 to $300,000, effective retroactively to January 1, 2022.

*Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate at the retiree self-contribution rate that would have been applicable to the retiree until or unless non-deferred participation (i.e., eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree's self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, or (b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Extended Retiree Spouse rates for the applicable benefit package.

Reminder: In addition to the other causal events stated in your Summary Plan Description, entitlement to MCTWF Retirees Plan benefits ceases as of the earlier of a) the first of the month in which the retiree's or spouse's 65th birthday falls or b) the date that the individual becomes eligible for early Medicare Part A coverage.

It is imperative that the individual immediately call to inform MCTWF of his early Medicare eligibility date and that the individual immediately cease the use of MCTWF Retiree benefits. MCTWF will ask the individual for a copy of the Medicare card or letter from the Social Security Administration stating the effective eligibility date. MCTWF will pursue recovery for any Retiree benefits paid for services incurred on or after the individual's Medicare eligibility date.

Retiree Enrollment and Deferral: WHAT YOU NEED TO KNOW (Spring 2023)
It is imperative that you follow the required time frames and do not jeopardize or delay your enrollment in the MCTWF Retirees Plan.

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. The retirement date is defined as the date an employee ceases to be covered by MCTWF as an active employee as a result of retirement, after application of all remaining benefit bank weeks (if applicable). MCTWF Retirees Plan 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, 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.

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. The retired individual must notify the Fund at such time as he wishes to commence 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
Those "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.

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 except in the following circumstances:

- 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.

When MCTWF Retirees Plan 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.

A MCTWF Retirees Plan Summary Plan Description Booklet, plus updated notifications, Summary of Benefits and Coverage and a full Schedule of Benefits also will be issued.

For more MCTWF Retirees Plan information, see Section 2.3 of the MCTWF Summary Plan Description Booklet, available on the homepage at www.mctwf.org.

Be Mindful of Benefit Changes When Not Actively Working (Summer/Fall 2023)
It is important to be mindful of your status as an employee with your employer.

MCTWF 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 are no longer 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 MCTWF unless you inform them otherwise.

MCTWF will be obliged to pursue you to recover the cost of benefits coverage erroneously provided to you.

Notification to Members of Important Policy Updates (Winter 2023-2024)
Updates, aimed at streamlining the process for the Retiree Medical Program, Benefit Bank Weeks, and Death Benefits, have been implemented recently. Please take a moment to review the notifications below.

Retiree Medical Program Eligibility
The Retiree Medical Benefit program is available under many of MCTWF's Benefit Packages for retirees who have reached the age of 57 and older and meet other requirements as described in your Summary Plan Description (SPD).

In 2014, the MCTWF Board of Trustees expanded the Retiree Medical Program eligibility requirements.
Approval in the Retiree Medical Benefit is defined as MCTWF's notification to the participant of the benefit approval AND receipt of required self-contributions.

Effective August 1, 2023, the Expanded Retiree Medical Benefit Program eligibility requirement has been approved to allow prior MCTWF participants to enroll in, or defer enrollment in, the Retiree Medical Program without being a MCTWF participant at the time of retirement or deferral.

If the retiree application is received 90 days beyond the participant's last date of MCTWF active coverage, the prospective retiree will be allowed to enroll and commence coverage for Retiree Medical Program benefits no earlier than the first day of the month that falls at least 90 days after MCTWF's receipt (and subsequent approval) of the prior participant's retiree application.

All other Retiree Medical Program requirements and Expanded Retiree Medical Benefit eligibility requirements apply to prior participants who qualify based on this updated eligibility requirement. Check the SPD for the full eligibility requirements.

Benefit Bank Weeks Retirement Status
In the past, MCTWF required that a participant who is reported by a contributing employer as "retired" meet certain criteria, as described in the Summary Plan Description (SPD), in order to be eligible for benefit bank week coverage.

Effective October 5, 2023, benefit bank week entitlement, based on retirement, will only be contingent upon the contributing employer reporting the retirement status change for the designated participant.

MCTWF will seek clarification from the participant and/or the contributing employer if there are any discrepancies regarding retirement status.

No further action is required by the retired participant.

MCTWF will base eligibility solely on the criteria set forth by the policy and the contributing employer report of the retirement status change for the designated participant.

Reminder: Participants are not eligible for benefit bank weeks when:

- A newly hired employee has not yet had contributions paid on his behalf for 8 consecutive weeks or 9 out of 13 weeks.
- An employee of a newly participating Employer has not yet had contributions paid on his behalf for 8 consecutive weeks or 9 out of 13 weeks.
- An employee quits.
- Employer discontinues participation in the Fund.
- Benefit package does not provide for such coverage.

Death Benefits
Death benefits are payable in the event of the death of an eligible employee, his/her spouse, and his/her children in the amounts shown in the employee's specific benefit package, subject to eligibility requirements. The death benefit for spouse or child will be paid to the employee.

All eligibility requirements, as listed in the Summary Plan Description (SPD) must be met.

A recent amendment to the eligibility requirements states that effective with participant or eligible dependent deaths that occur on or after August 1, 2023, the applicable death benefit will be payable if the death occurs within 31 calendar days (grace period) following the cessation of active coverage.

Active coverage is defined as the period following employer required contributions or full weekly accident and sickness benefit coverage only.

The death benefit would be payable if the 31-day grace period occurs while covered by benefit bank week eligibility.

The Accidental Death & Dismemberment benefit is not payable during the 31-calendar day grace period.

For any questions or concerns regarding any of the updates listed here, contact the Member Services Call Center, available Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800) 572-7687.

Disability Benefit Qualification Reminder

Many MCTWF benefit packages provide participants with various types of disability benefits if they become disabled and are unable to work. See your Summary Plan Description (SPD) and your Schedule of Benefits for any disability benefits available to you.

Under the Weekly Accident & Sick- ness Benefit, which applies to participants only, if you are disabled due to a non-occupational and non-auto related accidental injury, or sickness due to pregnancy while you are actively employed and are unable to perform the regular duties of your employment, you may qualify to receive a disability benefit. You will receive the weekly benefit amount and up to the maximum weeks available as indicated in your Schedule of Benefits. Please keep these important policy provisions in mind when applying for
any of the disability benefit plans:

- Every item on the application must be completed in full by yourself, your doctor, and your employer.
- Benefits cannot be considered unless the policy instructions are strictly complied with.
- Pay careful attention to details in completing the accidental injury portion of your claim.
- Benefits can only be paid if the disability is supported by medical evidence. The medical evidence has to be recorded by a licensed physician and it must show that you have been under his/ her personal and regular care throughout the disability period. Physicians who are authorized to make such determinations under the MCTWF Actives Plan must be either a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), or an Oral and Maxillofacial Surgeon. Note: Chiropractors are not approved by MCTWF to provide such evidence for MCTWF disability benefits.
- Regular care is important to the benefit plan because it is inconceivable that a person disabled, either as a result of sickness or accidental injury to the extent that he is unable to work, does not require reasonable medical attention from a physician. Do not jeopardize your claim for benefits. MCTWF may question or even deny benefits if you do not see your physician on a regular basis.
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For the complete list of Weekly Accident & Sickness Benefit requirements, refer to your SPD and Schedule of Benefits. Both are available at www. mctwf.org. The SPD is located on the homepage and there is a *Schedule of Benefits* page as well.

If you remain uncertain regarding your benefit entitlements, the MCTWF Member Services Call Center is available Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964- 2400 or Toll Free at (800) 572-7687.

Retiree Medical Benefit Package Rates for Plan Year April 2024 - March 2025 (Winter-Spring 2024)

The standard and expanded eligibility monthly self-contribution rates listed below apply to all those participating in the MCTWF Retirees Plan basic medical and prescription drug Benefit Package 145. For those purchasing Benefit Package 475 (which adds to the basic medical and prescription drug benefits the Retiree Supplemental Benefits Rider – Hearing, Vision, and Dental Plan 2 benefits), add $100.55 to Benefit Package 145 monthly rates. **Note: Participation in the MCTWF Retirees Plan is based on the eligibility rules as described in the MCTWF Summary Plan Description Booklet.**

April 2024 Retiree Medical Benefit Package 145 Standard Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	**5 – 9**	**10 – 14**	**15 – 19**	**20 – 24**	**25 – 29**	**30 +**
50 – 54	$760	$685	$625	$565	$485	$430
55 – 59	$590	$550	$510	$470	$435	$405
60 – 64	$430	$420	$405	$380	$375	$365
For eligible retirees whose active employment ceased prior to January 1, 2002: $365						

April 2024 Retiree Medical Benefit Package 145 Expanded Eligibility Monthly Self-Contribution Rates (Covers Both the Retiree and the Eligible Spouse)*						
	Years Participating in MCTWF under an Active Benefit Package with Retiree Medical Component					
Age at MCTWF Retirement Date	**5 – 9**	**10 – 14**	**15 – 19**	**20 – 24**	**25 – 29**	**30 +**
57 – 59	$650	$605	$560	$515	$480	$445
60 – 64	$470	$460	$445	$415	$410	$400

April 2024 Retiree Medical Benefit Package 145 Extended Retiree Spouse* Monthly Self-Contribution Rates (For Benefit Package 475, add $100.55)		
Age at Start of Each Plan Year	**Female**	**Male**
50 – 52	$624.25	$508.25
53 – 55	$681.15	$643.80
56 – 58	$707.00	$787.90
59 – 61	$732.05	$926.40
62 – 64	$773.65	$1,031.20

*Eligibility to participate in the MCTWF Retirees Plan (Benefit Package 145 or 475) ceases for the retiree or the spouse when he or she becomes eligible for Medicare Part A coverage or engages in prohibited employment (as defined by the Summary Plan Description Booklet). In the event that the retiree becomes eligible for Medicare Part A, the spouse may continue to participate at the retiree self-contribution rate that would have been applicable to the retiree until or unless non- deferred participation (i.e., eligibility for coverage) in the MCTWF Retirees Plan exceeds eight years. Spouse participation then requires self-contribution at the Extended Retiree Spouse rates for the applicable benefit package. If the retiree dies or becomes eligible for early age (disability) Medicare coverage, the otherwise eligible spouse may continue to participate at the retiree's self-contribution rate that would have been applicable to the retiree, unless or until the later of (a) eight years of non-deferred participation, or (b) until the date the retiree would have attained age 65, after which, for so long as she remains eligible, the spouse may continue to participate at the Extended Retiree Spouse rates for the applicable benefit package.

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

Benefit Bank Weeks Renewal Effective April 1, 2024 (Winter-Spring 2024)
We are pleased to announce that the Board of Trustees have renewed the MCTWF Benefit Bank Week allotment program for another 36 months, to commence following the March 31, 2024 expiration of the current 36-month period, for MCTWF benefit packages that include the New SOA, New Key 1, New Key 1a, New Key 1b, New Key 2, New Key 2a, New Key 2b, New Key 2c, New Key 2d, New Key 3, or New Key 3a medical benefits as follows:

- Eligible participants who are actively employed on or after April 1, 2024, will be allotted six benefit bank weeks for use during the period April 1, 2024 through March 31, 2027 during periods in which they are not actively employed. However, no benefit bank week coverage is available in the event that the participant quits his employment.
- Benefit bank week coverage includes the medical benefits and any prescription drug, dental, and vision benefits provided for in the participant's active benefit package. No Weekly Accident and Sickness, Total and Permanent Disability, or Death (or Accidental Death & Dismemberment) benefits will be available when incurred during the period covered by benefit bank weeks.
- Participants who are not actively employed on March 31, 2024 and who are receiving coverage due to their remaining benefit bank week allotment for the 2021 through 2024 period will continue to be covered until their remaining benefit bank weeks are exhausted, or, if earlier, upon their return to active employment. Once contributions are received with regard to the participant's resumption of active employment, the participant will receive a new allotment of six benefit bank weeks for use through March 31, 2027.

Family Status Changes Must be Reported to MCTWF in a Timely Manner (Winter-Spring 2024)
Family status changes, or certain information concerning participants and their beneficiaries (i.e., spouse and eligible children) is essential to MCTWF's accurate administration of the Plan.

As stated in your Summary Plan Description (SPD), MCTWF participants must provide all required documentation concerning themselves and all of their eligible beneficiaries to permit initial enrollment. It is absolutely necessary for participants to keep MCTWF informed of any change to their family status, including marriage, divorce, birth of child, adoption, change of address, change of email address, change of phone number, or other insurance information, etc.

You must notify the Fund immediately when you have a change in family status and complete and return the form along with the appropriate documentation (see Sec. 2.1 (a) of the SPD, for the list of required documentation).

The following are examples of changes that must be reported in a timely manner:

- 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
- in the case of divorce, death, or change of dependent child's status.

These family changes must be reported directly to MCTWF to avoid your 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.

Notification must occur immediately when such changes occur by submitting a *Change in Family Status Form* in cases of dependent eligibility, or a *Contact Update Form* in cases of changes in address, telephone number, and email address information.

Both forms are available on the Forms page of the MCTWF public website at www.mctwf.org or in the Document Center of your dashboard in the secure Participant Portal.

Also, please remember that dependent children lose coverage at the end of the month of their 26th birthday, and the dependent is offered COBRA continuation coverage at such time.

The applicable self-contribution costs for COBRA continuation coverage will also be provided at that time.

PART 3: MEDICAL BENEFITS – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

Important Update: Emergent Conditions Definition (Summer 2022)

In accordance with the 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 women 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 (BCBSM) that will avail members of Blue Cross Blue Shield (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 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 that are billed with a non-emergent condition diagnosis are reviewed for medical necessity based on the above criteria. Should the use of the emergency room be determined to not have been medically necessary, you will be responsible for payment.

Chiropractic Services Benefit Update (Summer 2022)

The MCTWF Actives Plan and MCTWF Retirees Plan pays for 24 spinal manipulations (once per day per person annually), 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 Blue Cross Blue Shield of Michigan (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 5/5/22, the "Per Day" limit for spinal manipulations has been removed, but the annual limit does not change.

Colonoscopy Wellness Benefit Changed to Age 45 (Summer 2022)

Colonoscopy or flexible sigmoidoscopy screening is provided once every five years to those age 45 years and older

(reduced from 50 in prior years).

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

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. In-network providers can be found by visiting www.mctwf.org on the "Provider Networks" tab.

MCTWF provides an array of wellness benefits for members. For all the details, refer to your Summary Plan Description.

MDLIVE Offers Behavioral Health Options (Summer 2022)
Since every May marks Mental Health Awareness month, it's important to note that MDLIVE, one of MCTWF's telehealth providers, has expanded its behavioral health services.

MDLIVE offers the following reasons for MCTWF members to explore their behavior therapy services:

Have your first therapy appointment in less time compared to the weeks or months it takes to schedule an in-person appointment.

- Easy to find a match – With thousands of licensed therapists in the MDLIVE network, it's easy to find a therapist that's the right fit for you.
- Flexibility – Choose the same provider for every visit or switch at any time. Convenient times are available, including weekends and evenings.
- Experience – MDLIVE licensed therapists have an average of over ten years of experience. MDLIVE licensed therapists and board-certified psychiatrists can get you back to feeling your best if you're feeling overwhelmed, stuck, or not like yourself. Common reasons to seek care include:

  - Addictions
  - Bipolar Disorders
  - Child and Adolescent Issues
  - Depression
  - Eating Disorders
  - Gay/Lesbian/Bisexual/Transgender Issues
  - Grief and Loss
  - Life Changes
  - Men's Issues
  - Panic Disorders
  - Parenting Issues
  - Postpartum Depression
  - Relationship and Marriage Issues
  - Stress
  - Trauma and PTSD
  - Women's Issues
  - General Support

All MDLIVE mental health professionals hold current licenses and have experience providing mental health support.

They also have experience in telehealth, which can make for a smoother transition when getting started with online therapy. Available professionals may depend on your location, but you can choose from distinct types of mental health professionals, such as: licensed clinical social workers, licensed professional counselors, licensed mental health counselors, licensed family therapists, psychologists, and psychiatrists.

MDLIVE members can review a therapist's profile and credentials before booking an appointment.

MDLIVE Offers Medical Visits and Behavioral Healthcare through MCTWF (Fall 2022)
Seven years ago, long before access to Telehealth (remote healthcare) was considered a necessity, MCTWF introduced a convenient service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE®. This telehealth service provides on-demand access to U.S. Board-certified physicians 24 hours per day, seven days a week, by phone, secure video, or through MDLIVE's mobile app for smartphones and tablets.

Patients can discuss their symptoms with a doctor, and prescriptions are sent immediately to the pharmacy of choice.

At home or on the road, treatment can begin right away.

Behavioral health consultations are available by appointment only, and secure video is considered the best mode for this type of consultation.

Medical visits and behavioral health consultations are available with a $0 copay through March 31, 2023. Below is a partial list of services available to MCTWF members after creating an MDLIVE account:

Urgent Care		**Behavioral Health Therapy and Psychiatry**	
Allergies	Medication Refills (Temporary, no Opioids)	Addictions	Obsessive Comp ulsive Disorder (OCD)
Birth Control	Pink Eye	Aging and Caregiver Support	Panic Disorders
Cold	Rash	Anxiety	Parenting Support
COVID-19 (no antivirals)	Sinus Problems	Bipolar	Phobias
Flu	Sore Throat	Depression	Relationship issues
Ear pain	UTI (18 and older)	Grief and Loss	Stress Management
Headache	Yeast Infections	LGBTQ+ Support	Trauma and PTSD
Insect Bites	And More	Life Changes	And More

For the full list of services, visit www.mdlnext.mdlive.com/what-we-treat. Download the MDLIVE mobile from the App Store, get it on Google Play, or link to it at the MCTWF website at www.mctwf.org, under the Info Links tab. For more information, call (800) 400-MDLIVE.

Board of Trustees Extends $0 Copay Policy for MDLIVE Telehealth Visits (Winter 2022 – 2023)
MCTWF members have free access to a convenient service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE®.

This telehealth service provides on-demand access to U.S. Board-certified physicians 24 hours per day, seven days a week, by phone, secure video, or through MDLIVE's mobile app for smartphones and tablets. Patients can discuss their symptoms with a doctor, and prescriptions are sent immediately to the pharmacy of choice.

At home or on the road, treatment can begin right away.

Behavioral health consultations are available by appointment only and secure video is considered the best mode for this type of consultation.

MCTWF's Trustees are extending the $0 copay policy for another year, through March 31, 2024.

Download the MDLIVE mobile app from the App store, get it on Google Play, or link to it at www.mctwf.org under the *Info Links* tab. For more information, please call (800) 400-MDLIVE.

Women's Health and Cancer Rights Act of 1998 (Winter 2022 – 2023)
The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 (ERISA) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

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

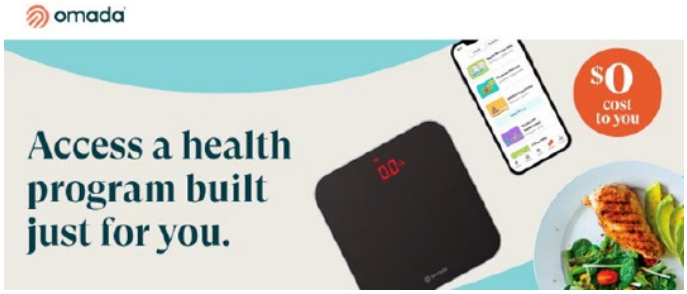
Coverage must include:

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

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

Increase in MCTWF Retirees Plan Calendar Year Benefit Limit (Winter 2022 – 2023)
The MCTWF Retirees Plan health (medical and prescription drug) benefits calendar annual benefit limit, exclusive of Phase III Specified Organ Transplants, per covered individual, has been increased from $250,000 to $300,000, effective retroactively to January 1, 2022.

Omada for Prediabetes (Winter 2022 - 2023)



Attention MCTWF Members,

The Fund offers Omada® as a covered benefit for all eligible employees. Omada is a personalized health program that helps members create healthier lifestyles through one-on-one personal coaching and the tools they need to make long-lasting changes.

The best part: the program — up to a $700 value — is offered at no cost to you, if you're eligible to join.

All members age 18 and older (with MCTWF medical benefits) are invited to submit an online application that will be reviewed by Omada. Those members who are determined to be at elevated risk for prediabetes pursuant to the Centers for Disease Control and Prevention (CDC) guidelines will be deemed eligible and invited to enroll in the program.

Members can get started by visiting www.omadahealth.com/mctwf, find the link at www.mctwf.org under the ***Info Links*** tab, or use this QR code to apply.

Livongo for Diabetes (Winter 2022 - 2023)

Mental Health Awareness - Five Things You May Not Know About Talk Therapy (Spring 2023)

May is Mental Health Awareness Month, and it's a good time to reflect on how you're feeling. If times are tough or you need help working through an issue, talk therapy is one of the best things you can do for yourself. Understandably, many people don't know how, or if, therapy will help. To clear up some confusion, here are five things you may not know about talk therapy from MDLIVE.

1. Therapy is proven to be effective.

Studies consistently prove that therapy is effective in producing long-term health improvements. In fact, over 75% of patients who seek help with an MDLIVE mental health professional report feeling better after just three visits.

2. Therapy helps with the day-to-day challenges.

You don't need to have severe mental health issues or suffer from a crisis to benefit from therapy. Everyone can feel better by talking to a caring professional, whether it's to overcome trauma or just make better life decisions.

A therapist can help you work through daily challenges, make more productive choices, learn valuable life skills, and achieve dreams and goals. Because therapy can increase problem-solving skills and confidence, it can also help you feel stronger when facing challenges.

3. Therapy improves overall health and wellbeing.

Being proactive about your mental health is essential for your long-term physical health, too. The American Heart Association recently noted that people who report positive mental health were more likely to have lower blood pressure, better blood sugar levels, and fewer physical symptoms of stress, including migraines, digestive troubles, and insomnia.

4. More people use therapy than you may think.

The COVID-19 pandemic brought mental health to the forefront and increased the number of people reaching out for help. It is estimated that 52.9 million American adults in 2020 experienced some mental health issues and almost half of those people (24.3 million) received mental health support. It is clear that more people are recognizing the value of talk therapy as a proactive way to feel better and stay healthy.

5. Virtual therapy is much more accessible.
Making an appointment for therapy can be a difficult first step for many people. Often, it can take weeks to get an appointment, and it may be hard to find the right therapist. With MDLIVE, have your first appointment in less than a week, and you can choose from MDLIVE's network of hundreds of licensed therapists. See the same therapist for every session, or switch at any time to find a better fit. Technology gives you easier, faster access to therapy from the comfort of home. Because it's secure, easy to use, and private, virtual therapy is becoming the new normal.

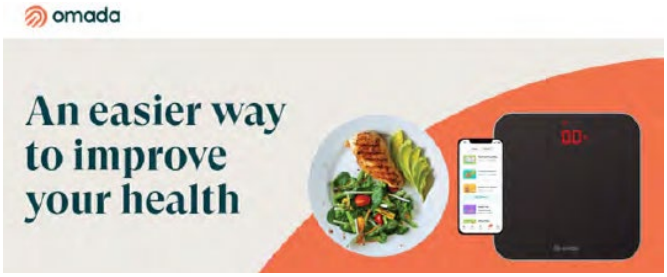
MDLIVE talk therapy is part of your MCTWF health benefits. To create a new account with MDLIVE, visit the Info Links page at www.mctwf.org.

If you're feeling anxious, overwhelmed, stressed, or depressed, or you simply need someone to talk to, schedule an appointment with an MDLIVE licensed therapist today.

Information provided by MD.

Applied Behavior Analysis (ABA) Services Benefit Improvement (Spring 2023)
Effective with dates of services January 1, 2022, and after, the age limit of 18 has been removed allowing coverage for ABA services for any individual who has been diagnosed with an autism spectrum disorder. For additional information regarding benefits for ABA services, the MCTWF Summary Plan Description Booklet is available on the MCTWF website by visiting www.mctwf.org, or you can contact Member Services Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or toll free at (800) 572-7687 with any questions.

Omada – An Easier Way to Improve your Health (Spring 2023)



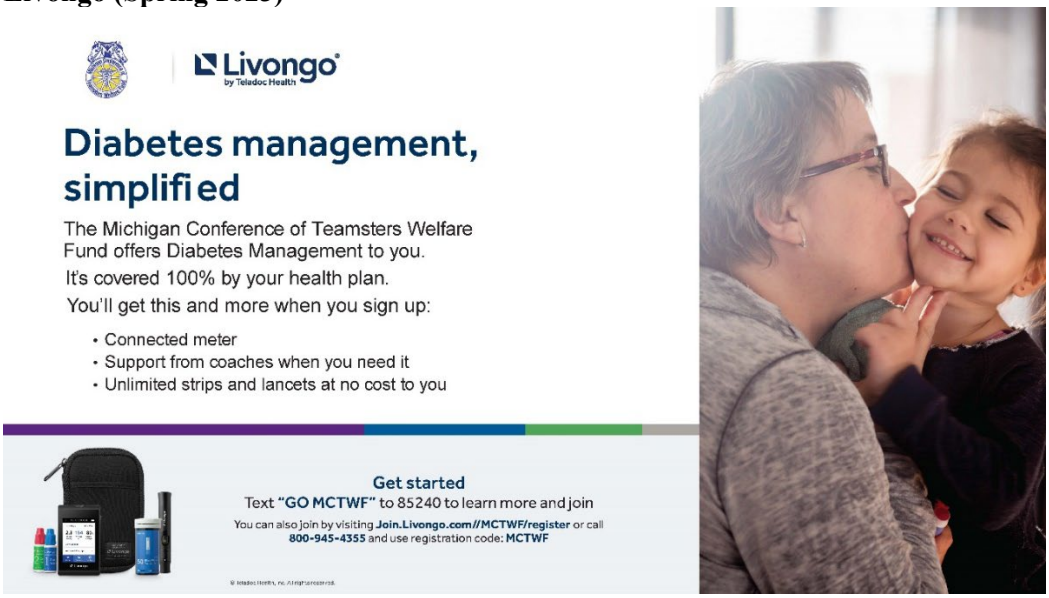
Omada® will help you see the weight loss results you want without cutting out the foods you love or counting calories. You'll learn to eat better, improve sleep, and lower stress with tips and support from your own Omada health coach.

Best of all, Omada is available at no additional cost to you if you're eligible.

All members aged 18 and older (with MCTWF medical benefits) are invited to submit an online application that will be reviewed by Omada. Those members who are determined to be at elevated risk for prediabetes pursuant to the Centers for Disease Control and Prevention (CDC) guidelines will be deemed eligible and invited to enroll in the program.

Members can get started by visiting www.omadahealth.com/mctwf, find the link at www.mctwf.org under the Info Links tab, or use this QR code to apply.

Livongo (Spring 2023)



Reduce Allergy Symptoms in No Time with MDLIVE (Spring 2023)

If you feel like your allergies are kicked in early this year, you're not alone. Doctors are predicting a bad spring/summer allergy season. MDLIVE board-certified physicians can assess your symptoms and develop an effective allergy treatment plan for you.

As a member of MCTWF, your telehealth appointment cost is $0.

With MDLIVE, you receive fast, reliable allergy care:

- Get a fast, accurate diagnosis and treatment at home.
- Talk to a doctor within minutes, 24/7, or schedule a time that's best for you.
- New prescriptions and refills sent to your nearest pharmacy, if medically necessary.
- Avoid long waits and rooms full of sick people.

Accurate allergy diagnoses are made using:

- Advanced clinical guidelines for virtual care.
- Temperature check or the use of photos.
- Thorough description of symptoms and current medications.

Visit www.MDLIVE.com/MCTWF today to access your MDLIVE telehealth services. A link to account information is also available on the Info Links page at www.mctwf.org.

Emergency Room or Urgent Care? (Summer/Fall 2023)

Your primary care doctor should be your first call in non-emergency situations. Your doctor knows you and your health history, including what medications you are taking and what chronic conditions might need to be considered in your treatment.

If you can't reach your doctor, or need care outside of regular office hours, urgent care centers are good options.

Urgent care centers have physicians on staff and can provide care for a greater range of conditions, including performing x-rays at some sites.

The out-of-pocket cost for visiting a clinic or urgent care center will cost less than a trip to the emergency room, but it's always a good idea to check to make sure the location you select is an in-network provider.
Blue Cross nurses are available — day or night — from the comfort of your home, or anywhere in the U.S., to help you decide where to go for care or provide you with recommended treatment options for minor illnesses. To speak to a registered nurse, call Blue Cross Health & Well-Being, toll free 24 hours a day, seven days a week at 1-800-775-BLUE (2583).
Emergency rooms are designed to treat acute, and life-threatening conditions and are not the appropriate place to seek routine care for minor ailments.

If you feel you are dealing with a real health emergency, call 911 or go to the emergency room right away.
Otherwise, one of the above options will save you time and money, and clear the way for patients in need of emergency treatment.
Specific language from the MCTWF Summary Plan Description for emergency Room Services includes, in part, the following (see the SPD for the full description):

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 women 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 under any MCTWF plans.
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.
Should the use of the emergency room be determined to not have been medically necessary by the Fund's Medical Director, you will be responsible for payment.

Update on Benefits: Air Ambulance Services (Summer/Fall 2023)
MCTWF pays eligible expenses for ground, air, or water licensed ambulance services for basic and advanced life support. Eligible expenses include basic charge for the trip, basic life-support services (BLS), limited advanced life-support services, advanced life-support services (ALS), specialty care transport (SCT), neonatal transportation services, mileage, oxygen (administration and supplies) 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 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, a 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.

Beginning May 2023, air ambulance services are payable only when ALL of the following criteria are met:

- Use of an air ambulance is medically necessary;
- Ordered in writing by a physician (M.D. or D.O), or in the case of an accidental injury emergency, a written order is not required, and the first responder's professional judgment will be relied upon when there is a need to order an air ambulance;

- The physician or first responder must have a reasonable expectation of significant time savings from 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.

Immunizations Help Keep Kids Healthy (Summer/Fall 2023)
Late summer through early fall is a time when many families begin preparing to send their children back to school.

This is a crucial time for families to add routine childhood and COVID-19 vaccinations to their back-to-school checklist. Vaccines are very safe. The United States' long-standing vaccine safety system ensures that vaccines are as safe as possible. Currently, the United States has the safest vaccine supply in its history. Millions of children safely receive vaccines each year. The most common side effects are very mild, such as pain or swelling at the injection site.

Vaccines can prevent infectious diseases that once killed or harmed many infants, children, and adults. Without vaccines, your child is at risk for getting seriously ill and suffering pain, disability, and even death from diseases like measles and whooping cough. The main risks associated with getting vaccines are side effects, which are almost always mild (redness and swelling at the injection site) and go away within a few days. Serious side effects after vaccination, such as a severe allergic reaction, are very rare and medical staff are trained to deal with them. The disease-prevention benefits of getting vaccines are much greater than the possible side effects for almost all children. The only exceptions to this are cases in which a child has a serious chronic medical condition like cancer or a disease that weakens the immune system, or has had a severe allergic reaction to a previous vaccine dose. Scientific studies and reviews continue to show no relationship between vaccines and autism.

Thanks to vaccines, children are protected from diseases like the following:
- Chickenpox
- Diphtheria
- Flu
- COVID-19
- Hepatitis A
- Hepatitis B
- Hib
- HPV
- Measles
- Meningococcal
- Mumps
- Polio
- Pneumococcal
- Rotavirus
- Rubella
- Tetanus
- Whooping Cough

Please see the Centers for Disease Control and Prevention (CDC) vaccine safety website for the full immunization schedule at https://www.cdc.gov/vac- cines/parents/schedules/index.html. Information provided by the CDC.

Avoid Back-to-School Illnesses (Summer/Fall 2023)
Backpacks are jammed with school supplies, closets are stocked with new clothes and shoes, and lunch- prep qualifies as a science at your house. Everybody's ready to go back to school, right? Not so fast. Are you prepared to protect your children from the bugs and crud they're likely to catch at school?

Here are five easy tips to help keep your children healthy and happy:
1. Teach kids to wash their hands properly. They should use warm water and plenty of soap, lather up to their lower arms and under their nails for 20 seconds, (teach them a little song to sing for 20 seconds) rinse with clean, warm water and dry their hands thoroughly.

2. Teach kids not to cover their cough with their hands. Cough into the fabric of a sleeve or pull out the neck of the shirt and cough toward their chest.

3. Have them eat plenty of fresh fruits and vegetables, and drink lots of water.

4. Make sure they get enough sleep at night. The National Sleep Foun- dation offers these guidelines: Children between 6 and 13 should sleep 9 to 11 hours Teens up to 17 should sleep 8 to 10 hours, and no fewer than 7 hours.

5. Let them play. Children from the ages of 6 to 17 should get at least one hour of moderate to vigorous activity every day to improve their fitness and increase their resistance to illness. According to the Centers for Disease Control, they should include 180 minutes (one hour, three times a week) of these types of activities:
   - aerobic exercises to improve their cardiovascular system (heart and lungs)—jogging, playing soccer, swimming.
   - weight-bearing exercises to strengthen their bones—running, jumping rope, climbing stairs, dancing.
   - muscle-building exercises, which also strengthen connective tissues (ligaments and tendons)—sit-ups, push-ups.
   - use of elastic exercise bands, and plenty of stretching to re- duce chance of injury.

Remember that you don't need to wait until the first day of class to ask for help. Many schools are open before the season starts to address any concerns a parent or child might have, including the specific health needs of a child. The best time to get help might be one to two weeks before school opens.

Tips provided by Livongo.

Omada Pre-Diabetes Program (Summer/Fall 2023)

Healthy is not one size fits all.

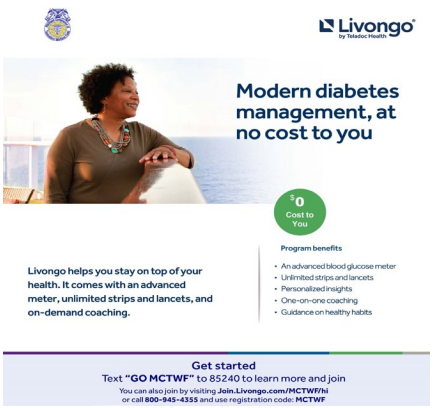
Omada® brings the human touch to virtual care. Get paired with an Omada health coach who will provide personalized support and guidance to help you manage weight and prevent chronic conditions between doctor visits and everyday life.

Best of all, Omada is available at no additional cost to MCTWF members, based on eligibility.

All members aged 18 and older (with MCTWF medical benefits) are invited to submit an online application that will be reviewed by Omada. Those members who are determined to be at elevated risk for prediabetes pursuant to the Centers for Disease Control and Prevention (CDC) guidelines will be deemed eligible and invited to enroll in the program.

Claim your welcome kit today by visiting www.omadahealth.com/mctwf, find the link at www.mctwf.org under the *Info Links*
tab, or use this QR code to apply.

Livongo Diabetes Management (Summer/Fall 2023)



MDLIVE Behavioral Health for Children and Teens (Summer/Fall 2023)
Heading back to school can trigger many different emotions like excitement, nervousness, or apprehension. More and more teens (and children) are struggling to process and cope effectively. If your child seems to be struggling, talk to them about it. If you decide on professional support, MDLIVE® licensed therapists and board-certified psychiatrists are here to help for children ages 10 and up — all from the convenience and privacy of home.

Signs that your Child or Teen May Need Support:

- Withdrawing from or avoiding people and activities they used to enjoy.
- Noticeable changes in their sleeping or eating patterns.
- Prolonged periods of sadness or hopelessness.
- Excessive worrying about their future.
- Out of control, self-destructive, or risky behaviors.
- Significant changes in their mood or personality.
- Difficulty concentrating.
- Use of drugs or alcohol.
- Speaking about or attempting to harm themselves.
- Talking about suicide.

Help your Child Thrive with MDLIVE Behavioral Health Virtual Visits (Summer/Fall 2023)
Give your child the support they need from the safety and privacy of home.

- Skip the waiting room with completely confidential virtual visits.
- MDLIVE has an extensive national network of board- certified psychiatrists and licensed therapists so selecting one who is a good match is simple and convenient.
- Pick the same provider for every appointment or choose a different one at any time.
- MDLIVE providers are specially trained in virtual behavioral health visits to provide the highest quality of compassionate healthcare.
- Schedule a session seven days a week — evenings and weekend appointments available.
- Access professional, reliable support that's included in your health plan.

MDLIVE licensed therapists offer talk therapy and coping strategies, and our board-certified psychiatrists can provide assessments and medication management. Make an appointment today and give your child the help and support they need. Visit https://members.mdlive.com/ mctwf for your free consultation at MDLIVE.

Emergency Room, Urgent Care or Telehealth? Make the Right Choice! (Winter-Spring 2024)
It is important that MCTWF members are aware that trips to the Emergency Room (ER) must be considered life or limb-threatening to receive full coverage. If you have a condition that is serious but not life threatening, a trip to the ER could cost you.

When medical conditions arise, a phone call to your general practitioner should be considered the first move.
In addition, urgent care or telehealth are alternatives covered under the MCTWF Actives Medical and MCTWF Retirees Medical Plans.

If you have a minor illness or injury that can't wait until your doctor's appointment, Urgent Care (most have extended hours) or MDLIVE® telehealth (available 24/7) are your best alternatives.

Find Urgent Care providers in your network at www.bcbsm.com or access your MDLIVE telehealth services.

In general, as stated in your Summary Description Plan booklet (SPD), 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.**

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 women or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

MCTWF members who seek treatment at an ER, in cases where the services are deemed as non- emergent, will be held responsible for large out-of-pocket ER fees.

For further information, refer to your SPD or view the SPD on MCTWF's *Home Page* at www.mctwf.org.

Board of Trustees Extends $0 Copay Policy for MDLIVE Telehealth Visits (Winter-Spring 2024)
MCTWF members have free access to a convenient telehealth service for the treatment of many non-acute medical conditions through the use of remote consultations provided by MDLIVE.

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

Patients can discuss their symptoms with a doctor, and prescriptions, if applicable, are sent immediately to the pharmacy of choice.

At home, or on the road, treatment can begin right away.

In addition, behavioral health consultations are available by appointment only. Secure video, while not required, is considered the best experience for this type of telehealth consultation.

MCTWF's Trustees are extending the $0 copay for another year, through March 31, 2025.

Download the MDLIVE mobile app from the App store, get it on Google Play, or link to it at www.mctwf.org under the Info Links tab. For more information, call (800) 400-MDLIVE or (888) 632-2738.

Omada Prediabetes Program (Winter-Spring 2024)

Great news! The Fund offers Omada to help members lose weight and create healthier habits with one-on-one personal coaching and the tools needed to make long-lasting health changes. The best part: the program is no cost to you if you're eligible to join.

- **Apply today and you could get your welcome kit in just 10 days once enrolled.**
- **Your welcome kit includes an easy-to-use smart scale, shipped to your door and yours to keep.**
- **See how Omada can help you. It only takes a few minutes to get started.**

All MCTWF members aged 18 and older (with MCTWF medical benefits) are invited to submit an online application that will be reviewed by Omada. Those members who are determined to be at elevated risk for prediabetes pursuant to the Centers for Disease Control and Prevention (CDC) guidelines will be deemed eligible and invited to enroll in the program.

Claim your benefit by visiting www.omadahealth.com/mctwf, find the link at www.mctwf.org under the *Info Links* tab, or use the QR code to apply.

Teladoc Health Diabetes Management Program (Winter-Spring 2024)

What is Type 2 Diabetes? (Winter-Spring 2024)
Type 2 diabetes is the most common form of diabetes mellitus, a group of health conditions linked to having high blood sugar, also known as hyperglycemia. When you have type 2 diabetes, your body can't effectively process the glucose (sugar) in your blood that provides energy to your body's cells. This causes you to have chronically high blood sugar levels.

The two other main conditions under the diabetes umbrella are type 1 diabetes and gestational diabetes, which affects a person during pregnancy.

Type 2 diabetes accounts for 90 to 95 percent of all diabetes cases in the United States. That's upwards of 35 million U.S. adults and children living with the disease today.

Type 2 diabetes disrupts the way your body uses blood sugar. This can lead to issues with the way your body stores and uses fat and other energy sources. The condition is caused by several factors, which may include:
Insulin resistance

- Overweight/obesity and physical inactivity
- Genes and family history

For more information, visit www.cdc.gov/diabetes/basics/type2.

Mental Health Awareness (Winter-Spring 2024)
In addition to traditional mental health benefits available under all MCTWF Plans with medical coverage, MDLIVE also offers virtual telehealth mental health treatment.

PART 4 : WEEKLY ACCIDENT AND SICKNESS BENEFITS – MCTWF ACTIVES PLAN

Short-Term Disability (Summer 2022)
Weekly Accident and Sickness (A&S) benefits provide short-term disability income and eligibility for other benefit package components, if applicable, during the covered period of a disability. MCTWF Actives Plan participants 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, participants do remain eligible for disability income benefits), or pregnancy.

Beneficiaries (i.e., spouse and dependent children) are not eligible to receive this benefit. Full benefit details are described in your Summary Plan Description.

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) etc.; 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.

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. Note: Once the participant retires, he/she is no longer eligible for A&S benefits. If any A&S benefits are paid beyond the retirement date, or the date the participant is no longer eligible for the benefit, the participant will be pursued for the A&S benefit overpayment.

PART 6: PRESCRIPTION DRUG BENEFITS – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

Drug Category – Vision Enhancement Agents (Summer 2022)
CVS/Caremark has established a new drug category called Vision Enhancement Agents. This category currently contains the following prescription ophthalmic products used to improve field of vision: Vuity (pilocarpine, AbbVie), Upneeq (oxymetazoline, RVL Pharmaceuticals), and Acuvue Theravision (etafilcon).

These three prescription medications are considered cosmetic and therefore are not covered under your MCTWF benefit package effective August 1, 2022.

This excluded category of ophthalmic prescription medications will be updated as additional products become U.S. Food and Drug Administration approved.

KERENDIA® (finerenone) Medication (Summer 2022)
Kerendia (finerenone) oral tablets were approved by the FDA on July 9, 2021, to reduce the risk of kidney function decline, kidney failure, cardiovascular death, non-fatal heart attacks, and hospitalization for heart failure in adults with chronic kidney disease associated with type 2 diabetes. Kerendia is a non-specialty brand medication.

To ensure appropriate use of this new therapy, prior authorization will be required effective July 15, 2022. To obtain approval to have this medication covered, the prescribing physician must contact CVS/Caremark at (800) 626-3046.

New Pharmacy Benefit: Disposable Insulin Pumps for Type 1 Diabetics (Fall 2022)
Effective November 15, 2022, MCTWF is providing a new CVS/Caremark pharmacy benefit that will cover specific disposable insulin pumps, including the Omnipod 5. After discussing the availability of a disposable insulin pump with the patient's physician, if the patient is eligible for this method of insulin delivery, the physician will submit a prescription to the pharmacy. The patient will be charged the applicable Brand copayment for each prescription fill. Omnipod 5 is an automated insulin delivery system which integrates with the Dexcom Continuous Glucose Monitoring (CGM) System, and is cleared for people with type 1 diabetes, aged 6 years and older.

Omnipod 5 products can help to simplify life with diabetes:

- No multiple daily injections, tubes, or fingersticks* necessary.
- Helps keep users in range day and night. Monitors glucose levels and insulin dosing all with
- the option for full control right from your compatible
- smartphone.
- Each Pod still lets you trade multiple daily injections for up to 3 days (72 hours) of continuous insulin delivery.

For a complete description of the Omnipod products please visit www.omnipod.com.

*Fingersticks are required for diabetes treatment decisions if symptoms or expectations do not match readings.

New Pharmacy Benefit: Access to COVID-19 Antiviral Medication (Fall 2022)
PAXLOVID® is a COVID-19 antiviral medication used to treat mild-to-moderate COVID-19 in adults and children (12 years of age and older weighing at least 88 pounds) with positive results of direct SARS-CoV-2 viral testing, and who are at elevated risk for progression to severe COVID-19, including hospitalization or death.

Recently, the Federal Drug Administration (FDA) revised its emergency use authorization to allow state-licensed pharmacists to prescribe the oral antiviral medication, Paxlovid.

Effective October 15, 2022, MCTWF members will be able to request and fill a prescription for Paxlovid through participating pharmacies.

Participating CVS® pharmacy pharmacists can prescribe and fill Paxlovid, for those that are eligible for treatment. Participation by other network pharmacies will be based upon the availability of the service at their individual locations. Members must contact the network pharmacy within 3 days of symptoms to determine eligibility for Paxlovid.

Pharmacists will:

- Determine your eligibility for Paxlovid.
- Prescribe Paxlovid if you're eligible.
- Refer you for additional evaluation if you're deemed not eligible.

Visit Caremark.com/findapharmacy to find a participating network pharmacy near you and contact them to see if they offer treatment for COVID-19.

The cost of the participating pharmacist assessment is covered under your prescription drug benefit in full and there is currently no cost to members for Paxlovid.
If you test positive for COVID-19, ask your physician if Paxlovid can help you with a fast recovery.

Notice of Creditable Coverage (Fall 2022)
All MCTWF Actives Plan and MCTWF Retirees Plan Prescription Drug Coverage

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

Important Notice from the Michigan Conference of Teamsters Welfare Fund (MCTWF) About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MCTWF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage.

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

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

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF prescription drug coverage and Medicare prescription drug coverage, MCTWF

prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF COBRA coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug plan coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (longer than a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), FDA-approved products that are lidocaine or lidocaine-containing formulations (after the first month's fill), dosage, duration and other criteria based fills for opioids and buprenorphine mono products, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, subject to generic and brand copays, as detailed in your Summary Plan Description booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
You also should know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…
Contact MCTWF's Member Services Call Center at (313) 964-2400 or (800) 572-7687. NOTE: You'll receive this notice each year. You also will get one before the next period you can join a Medicare drug plan or if this coverage through MCTWF changes. You may request a copy of this notice at any time.
For more information about your options under Medicare prescription drug coverage…
Detailed information about Medicare plans offering prescription drug coverage is in the "Medicare & You" handbook. You should receive a copy of the handbook in the mail each year from Medicare. You also may be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
September 1, 2022
Michigan Conference of Teamsters Welfare Fund

CVS/Caremark Standard Formulary Exclusions and Additions (Winter 2022 – 2023)
The following list reflects those prescription medications that, effective January 1, 2023, are either newly excluded from CVS/ Caremark's Standard Formulary (and therefore require prior authorization to establish medical necessity) or have been added to the Standard Formulary. Please note that listed generic drugs are in lowercase font and brand drugs are in UPPERCASE font. CVS/ Caremark has notified current utilizers and their prescribing physician of the newly excluded drugs and provided a list of covered alternative drugs that are therapeutically equivalent. In order to obtain prior authorization, your physician must contact CVS/Caremark at (800) 626-3046.

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

Common Condition/ Therapeutic Class	Drug Newly Excluded from Standard Formulary Effective 1/1/23 (Subject to Prior Authorization)	Recommended Alternative Generic or Brand Drugs in Therapeutic Class (note: the below listed generics are not the direct generic equivalent of the brand drug that is subject to Prior Authorization)	Drugs Added or Added Back to Standard Formulary Effective 1/1/23 (No Longer Subject to Prior Authorization)
Antiarrhythmics	MULTAQ, NEXTERONE	amiodarone	
Anti-Inflammatory, Cryopyrin-Associated Periodic Syndromes (CAPS)	ARCALYST	ILARIS	
Asthma, Severe	NUCALA LYOPHILIZED	DUPIXENT, FASENRA, NUCALA (except lyophilized powder), TEZSPIRE, XOLAIR	
Asthma, Steroid Inhalants	ARNUITY ELLIPTA, FLOVENT DISKUS, QVAR REDIHALER	FLOVENT HFA, PULMICORT FLEXHALER	
Attention Deficit Hyperactivity Disorder	ADDERALL XR		amphetamine-dextroamphetamine ext-rel
	CONCERTA		methylphenidate ext-rel
Autoimmune Agents			ILUMYA
Atopic Dermatitis			ADBRY, CIBINQO
Cancer, Antimetabolites	ALIMTA	pemetrexed	
Cancer, Follicular Lymphoma Phosphatidylinositol-3-kinase (PI3K) Inhibitors			ZYDELIG
Cancer, Poly-ADP Ribose Polymerase (PARP) Inhibitors	RUBRACA	LYNPARZA, ZEJULA	
Cancer, Rearranged During Transfection (RET) Inhibitors			GAVRETO, RETEVMO
Cancer, Renal Cell Carcinoma	SUTENT, VOTRIENT	sunitinib, CABOMETYX, INLYTA, LENVIMA, NEXAVAR	
Dermatology, Acne Products			WINLEVI
Endocrine, Metabolic Modifiers	NITYR	ORFADIN	
Hematologic, Hemophilia B	BENEFIX, IXINITY, RIXUBIS	ALPROLIX, REBINYN	ALPROLIX
Hematologic, Thrombocytopenia Agents			MULPLETA (non-preferred)
Hereditary Angioedema	FIRAZYR	icatibant, RUCONEST	
Migraine, Calcitonin Gene-Related Peptide Inhibitors (CGRP) Inhibitors*			AIMOVIG
Overactive Bladder, Incontinence, Urinary Antispasmodics	TOVIAZ	darifenacin ext-rel, oxybutynin ext-rel, solifenacin, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, GEMTESA	
Pain & Inflammation, Non-steroidal Anti-Inflammatory Drugs (NSAIDs)*	diclofenac capsule 25 mg	diclofenac sodium, ibuprofen, meloxicam tablet, naproxen (except naproxen CR or naproxen suspension)	
	diclofenac solution 2%	diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution 1.5%, ibuprofen, meloxicam tablet, naproxen (except naproxen CR or naproxen suspension)	
Pain, Opioid Analgesics	NUCYNTA	hydromorphone, morphine, oxycodone	
	NUCYNTA ER	fentanyl transdermal, hydrocodone ext-rel, hydromorphone ext-rel, methadone, morphine ext-rel, XTAMPZA ER	
Parkinson's Disease			RYTARY
Pulmonary Fibrosis Agents	ESBRIET	pirfenidone, OFEV	
Sleep Disorders	EDLUAR	doxepin, eszopiclone, ramelteon, zolpidem, zolpidem ext-rel, BELSOMRA, DAYVIGO	DAYVIGO
Ulcerative Colitis	ASACOL HD		mesalamine delayed-rel tablet 800 mg

Generic Drugs: A Safe and Cost-Effective Choice (Spring 2023)
Generic drugs are medications with the exact same active ingredient as brand-name drugs, taken the same way and offer the same effect. They do not need to contain the same inactive ingredients (flavoring or preservatives) as the name-brand product and they can only be sold after the brand-name drug's patent expires.
Generic drugs offer the same quality as brand-name medications. They work just like their brand-name equivalents in dosage, strength, performance, and use. Generic drugs are required to meet the same quality and safety standards set by the U.S. Food and Drug Administration (FDA).

There are only two main differences between generic and brand-name drugs:

- The inactive ingredients, such as flavoring or preservatives, may change; and
- Generics generally cost less than brand-name versions.

The U.S. Food and Drug Administration sets standards for generic drugs to ensure they work the same way and have the same benefits and risks as their brand-name counterparts.

Generic drugs must match the brand-name versions in the following ways:

- They must have the same active ingredients;
- The dosage and strength must be identical; and
- The overall quality, stability and safety must be the same.

A generic drug must be "bioequivalent" to the brand-name product, meaning they have to be chemically similar. A recent study that compared generics to brand-name drugs found, on average, only a 3.5% difference in absorption into the body. Generic drugs are just as effective, and they offer an average of 30%-80% savings over their brand-name counterparts. (Based on CVS/Caremark retail cash prices.)

Cost-saving generic medications are available for many prescription medications. Always talk to your doctor about the best course of your treatment. Some medicines don't have a generic version but your doctor or pharmacist can see if there are alternatives you can try. You may find the savings are well worth the change.

Information provided by CVS/Caremark.

For the full CVS/Caremark Performance Drug list, including generics, visit the Info Links page at www.mctwf.com.

Antidiabetic GLP-1 and GIP/GLP-1 Agonists Utilization Management Program for Diabetic Patients
(Spring 2023)
Effective July 1, 2023, a new CVS/Caremark utilization management program for Antidiabetic GLP-1 and GIP/GLP-1 Agonist medications will require members who are newly prescribed these medications, to obtain prior authorization before the medication will be covered.

Glucagon-like peptide (GLP-1) and gastric inhibitory polypeptide (GIP) are classes of drugs used with a proper diet and exercise program to control high blood sugar in people with Type 2 diabetes mellitus. Because this medication is being used by patients who have not been diagnosed with Type 2 diabetes mellitus, and thereby creating shortages of the medications, prior authorization will be required.

Current MCTWF members who have filled a prescription for at least a 30-day supply of any antidiabetic medication in the past two years, will not be subject to the prior authorization process. Written communication is being sent to any members (and physicians who prescribed the medication) who have had an antidiabetic medication filled that does not meet the utilization criteria to bypass the prior authorization process. Physicians can obtain prior authorization for the antidiabetic medication for Fund members by calling CVS/Caremark at (800) 294-5979. If you have any questions, the MCTWF Member Services Call Center is available Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800) 572-7687.

Notice of Creditable Coverage (Summer/Fall 2023)

All MCTWF Actives Plan and MCTWF Retirees Plan Prescription Drug Coverage

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

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

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

know about your current coverage and Medicare's prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. MCTWF has determined that the prescription drug coverage offered by all MCTWF benefit packages with prescription drug coverage, on average for all plan members, is expected to pay out as much as standard Medicare prescription drug coverage pays and therefore is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

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

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

If you decide to join a Medicare drug plan, under MCTWF rules you nonetheless may not drop your MCTWF prescription drug coverage. If you have both MCTWF Actives Plan prescription drug coverage and Medicare prescription drug coverage, MCTWF Actives Plan prescription drug coverage will be primary and your Medicare prescription drug plan will be secondary. If you are a COBRA beneficiary you may drop your MCTWF coverage in full, including prescription drug coverage, and enroll in a Medicare prescription drug plan. However, you will not be able to get your MCTWF COBRA coverage back later. If you do elect COBRA continuation coverage, your COBRA prescription drug coverage will be secondary to your Medicare prescription drug plan coverage. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current prescription drug plan provides comprehensive coverage for eligible prescription drugs, subject to preauthorization requirements for certain brand name prescription drugs and for prescription drugs within the following drug classifications: compound drugs, proton pump inhibitors (longer than a 90 day generic supply during a 365 day period, or if a brand is requested), selective serotonin reuptake inhibitors (brand name only), FDA-approved products that are lidocaine or lidocaine-containing formulations (after the first month's fill), dosage, duration and other criteria based fills for opioids and buprenorphine mono products, anabolic steroids, anti-obesity, ADHD/narcolepsy (age 20 and above), acne, and oral anti-fungal drugs, subject to generic and brand copays, as detailed in your Summary Plan Description booklet. Your current coverage pays for other health expenses, in addition to prescription drugs, and you still will be eligible to receive all of your current MCTWF Actives Plan health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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

You also should know that if you drop or lose your current coverage with MCTWF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact MCTWF's Member Services Call Center at (313) 964-2400 or (800) 572-7687. NOTE: You'll receive this notice each year. You also will get one before the next period you can join a Medicare drug plan or if this coverage through MCTWF changes. You may request a copy of this notice at any time.

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
September 1, 2023
Michigan Conference of Teamsters Welfare Fund

PART 7: DENTAL PROVIDERS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

Predeterminations are Recommended for Dental Work Over $200 (Winter 2022 – 2023)
A predetermination can prevent costly surprises by providing estimates regarding how much certain dental services will cost you under your MCTWF dental plan.

A predetermination is an estimate provided prior to dental treatment informing you:
If the treatment is covered.

- The allowed amount that can be paid by MCTWF.
- The amount for which you will be responsible.

This is a free, optional service provided to members to help you make an informed decision about your dental treatment and associated costs.

A predetermination is not a guarantee of payment – it is an estimate of what you can expect to owe.

You may want to ask your dentist to submit a predetermination to MCTWF for more expensive procedures or extensive treatment. Typically, this would include procedures such as crowns, bridges, root canals, removal of wisdom teeth, periodontal treatment, and other high-cost treatments.

A predetermination estimate allows you to find out in advance what is covered and what your share of the costs will be before you receive the service. Some dental services may be limited or not covered by your plan. Any deductible or maximums applied are included.

Once you receive the predetermination, you can make an informed decision about whether you want to proceed with the treatment, or discuss alternative options with your dentist.

Dental Benefit for Occlusal Guards (Spring 2023)
An occlusal guard is a removable dental appliance that is designed to minimize the effects of bruxism (grinding of the teeth) and other occlusal factors. An occlusal guard from a dental office is custom made for a specific patient's requirements.

The occlusal guard, adjustments, and relines to the appliance are covered benefits under the MCTWF Actives Plan and MCTWF Retirees Plan Supplemental Benefits Rider dental benefit as Class II basic restorative services. These benefits apply

toward the annual dental benefit maximum and, if applicable, toward the dental benefit deductible (for Dental Plans 2 and 3).

Effective with dates of services February 2, 2023 and after, MCTWF dental benefit limitation for the occlusal guard will be payable once in a five-year period. Previously, the occlusal guard was payable once per lifetime.

The dental benefit limitation for adjustments and relines will remain as follows:

- Occlusal guard complete adjustment is payable once per sixty-month period.
- Occlusal guard limited adjustment is payable not more than three times in a sixty-month period.
- Occlusal guard reline is payable once per thirty-six-month period.

PART 9 : DEATH BENEFITS - MCTWF ACTIVES PLAN

Designating and Updating your Death Benefit Beneficiaries (Spring 2023)
MCTWF's Summary Plan Description Booklet states that death benefits will be paid to the named beneficiary most recently listed on your Enrollment Card or Change of Beneficiary Form (or for Retiree death benefits, the Death Benefit Program Election Form).

Regardless of a 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.

Also, before payment of a death benefit can be made to a designated beneficiary who is a minor, an order issued by the probate court appointing a guardian or conservator with full authority to access, receive, and dispose of the named minor's assets must be provided to MCTWF.

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 Booklet rules prevail. 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.

PART 13: HOW TO FILE A CLAIM – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

Important Notice: Federal No Surprises Act Now in Effect (Summer 2022)
The Federal No Surprises Act (NSA) became effective April 1, 2022. The law aims to help patients understand health care costs in advance of care and to minimize unforeseen or "surprise" medical bills.

Unforeseen medical bills can happen when a patient receives emergency or scheduled clinical care or services from a provider or facility that is considered out-of-network or non-participating by that patient's insurance plan. Sometimes a patient is unaware they are receiving out-of-network services. These surprise bills are often called "balance billing" or "out-of-network billing." Providers and facilities are required to provide you with the following information regarding the NSA.

An exception to federal surprise billing protections is allowed if patients give prior written consent to waive their rights under the NSA and be billed more by out-of-network providers. Providers are never allowed to ask patients to waive their rights for emergency services or for certain other non-emergency services or situations addressed in the NSA.

Your Rights and Protections Against Surprise Medical Bills*

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

*The information contained in this notice, and additional details, can be found by visiting https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities- health.pdf

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Centers for Medicare & Medicaid Services (CMS) No Surprises Help Desk at (800) 985-3059 from 8 a.m. to 8 p.m. EST, seven days a week, for questions/complaints or visit https://www. cms.gov/nosurprises for additional information about your rights under federal law.
MCTWF medical benefits are in compliance with the No Surprises Act.

PART 17: COORDINATION OF BENEFITS – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

Coordination of Benefits Update (Winter-Spring 2024)
Coordination of Benefits (COB) is a way to figure out who pays first when an employee has two or more health insurance plans. For dependent children, the Summary Plan Description (SPD) explains 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, then that parent's plan is the Primary Plan.

If that designated parent has no health care coverage, but his spouse does, then 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.

For adult children over the age 18, the order of benefits for the adult child are as follows:

a) the plan covering the parent whose birthdate is earlier in the year,
b) The plan covering spouse of the parent who is primary,
c) The plan covering parent with the later birthdate.
d) The plan covering spouse of parent with later birthdate.

For additional details and other rules, refer to section 17.1 in your SPD.

PART 19: YOUR RIGHTS UNDER ERISA – MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

MCTWF's New Summary Plan Description is Available and On the Way! (Summer 2022)
A new Summary Plan Description (SPD) booklet is on the way to participants. The SPD provides general information about the MCTWF Actives Plan and MCTWF Retirees Plan effective as of April 2022. Along with the SPD, you will receive the MCTWF Schedule of Benefits specific to your benefit package that describes what benefits are covered and your cost sharing requirements.

The Summary Plan Description is required by The Employee Retirement Income Security Act (ERISA) of 1974. The purpose of this Summary Plan Description is to acquaint participants with the provisions of the MCTWF plans, the way in which they are administered, and participants' rights under the federal law which applies to employee benefit plans.

Every effort has been made to make this Summary Plan Description as accurate as possible. All updates to the plan are mailed to participants in the form of the Messenger newsletter and other direct mailings. The new SPD is also available on the website at www.mctwf.org. A new Messenger Compilation will also be available on the website. An archive of past Messengers is located on the website at www.mctwf.org.

New MCTWF Participant Web Portal Coming Soon (Summer 2022)
MCTWF is in the process of upgrading the Participant Portal. This useful tool provides access to your protected health information maintained by MCTWF through a fully secured personal account and is accessible from our website home page at www.mctwf.org.

Expected to launch soon, the new "Participant Web Portal" will provide improved navigation and appearance.
Everyone who wishes to access the new portal will be required to create an account – even if you have an account on the current portal. By creating a new Participant Web Portal account when it becomes available, you will continue to have access to:

- Participant screen which displays the participant's contract number, date of birth, gender, current benefit plan, number of benefit bank weeks remaining, if applicable, current address, phone number and marital status.
- If you find that your address or phone number information is not correct, you can go to the Account Maintenance screen to update and submit the corrected information.
- Family screen that displays each covered family member's name, date of birth, relation to participant.
- Short-Term Disability and the date through which coverage is available.
- Eligibility History screen covers all periods of eligibility for each family member.
- Plan Limits screen displays your family and individual accruals for the current and prior calendar year towards calendar year dollar limits available and used for applicable medical and dental benefits.
- Claims screen gives you the ability to reprint any Explanation of Benefits (EOB) as well as update beneficiaries and account information.

MCTWF's New Participant Web Portal is Live! (Winter 2022 – 2023)
MCTWF has upgraded a series of systems and software to provide more efficient service to our members.

Included in the upgrades is the new "Participant Web Portal" found on the home page of the Fund website at www.mctwf.org.

This useful tool provides secure access to your protected health information maintained by MCTWF through a fully secured personal account.

The new Participant Web Portal provides improved navigation, security, and appearance. Members who wish to access the new portal will have to create a new private account – even if you had an account on the old portal, which is no longer available.

By creating a new Participant Web Portal account, you will have access to:

- Participant Dashboard which provides easy access to all services.
- Health Claim screen which provides dates, amounts of claims paid, Explanation Of Benefits (EOBs), and the member's claim history. EOBs can be printed from there.
- Deductibles page displays deductible amounts met for the current year based on claims processed.
- Beneficiaries screen provides the list of those dependents eligible for coverage.
- Document Center has all MCTWF forms for easy access.
- Disability Payments screen keeps a record of any disability claims, if applicable to the member's benefit package.

- Demographics screen displays contact information for covered individuals.

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

Summary Annual Reports for MCTWF Actives Plan and MCTWF Retirees Plan Participants (Winter 2022 – 2023)

Summary Annual Reports for MCTWF Actives Plan and MCTWF Retirees Plan Participants Michigan Conference of Teamsters Welfare Fund Plan Year Ended March 31, 2022

For MCTWF Actives Plan

This is a summary of the annual report of the MCTWF ACTIVES PLAN, EIN 38-1328578, Plan No. 501, for period April 1, 2021, through March 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $539,536,125 as of March 31, 2022, compared to $547,179,453 as of April 1, 2021. During the plan year the plan experienced a decrease in its net assets of $7,643,328. This decrease includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $300,905,587, including employer contributions of $298,279,615, employee contributions of $1,009,745, earnings from investments of $1,614,334, and other income of $1,893.

Plan expenses were $308,548,915. These expenses included $14,386,848 in administrative expenses, and $294,162,067 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- an accountant's report;
- financial information;
- assets held for investment;
- information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates;

To obtain a copy of the full annual report, or any part thereof, write or call the office of TRUSTEES OF MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND in care of KYLE STALLMAN who is Plan Administrator at 2700 TRUMBULL AVENUE, DETROIT, MI 48216, or by telephone at (313) 964-2400. The charge to cover copying costs will be $2.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan (TRUSTEES OF MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND, 2700 TRUMBULL AVENUE, DETROIT, MI 48216) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room N -1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

For MCTWF Retirees Plan

This is a summary of the annual report of the MCTWF RETIREES PLAN, EIN 38-1328578, Plan No. 502, for period April 1, 2021 through March 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $55,352,283 as of March 31, 2022, compared to $55,654,420 as of April 1, 2021. During the plan year the plan experienced a decrease in its net assets of $302,137. This decrease includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $8,976,973, including employer contributions of $5,915,334, employee contributions of $3,236,895, earnings from investments of ($175,288), and other income of $32.

Plan expenses were $9,279,110. These expenses included $675,211 in administrative expenses, and $8,603,899 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- an accountant's report;
- financial information;
- assets held for investment;
- information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates;

To obtain a copy of the full annual report, or any part thereof, write or call the office of TRUSTEES OF MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND in care of KYLE STALLMAN who is Plan Administrator at 2700 TRUMBULL AVENUE, DETROIT, MI 48216, or by telephone at (313) 964-2400. The charge to cover copying costs will be $2.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan (TRUSTEES OF MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND, 2700 TRUMBULL AVENUE, DETROIT, MI 48216) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room N -1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Visit www.mctwf.org to stay informed.

Summary Annual Reports for MCTWF Actives Plan and MCTWF Retirees Plan Participants (Winter-Spring 2024)

Summary Annual Reports for MCTWF Actives Plan and MCTWF Retirees Plan Participants Michigan Conference of Teamsters Welfare Fund Plan Year Ended March 31, 2023

For MCTWF Actives Plan

This is a summary of the annual report of the MCTWF Actives Plan, a health, life insurance, dental, vision, temporary disability, longterm disability and death benefits plan (Employer Identification Number 38-1328578, Plan Number 501), for the plan year 04/01/2022 through 03/31/2023. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $495,505,783 as of the end of plan year, compared to $539,536,125 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of ($44,030,342). This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $280,216,595 including employer contributions of $319,506,709, employee contributions of $793,076, earnings from investments of ($40,169,213), and other income of $86,023. Plan expenses were $324,246,937. These expenses included $15,036,094 in administrative expenses and $309,210,843 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report.
2. Financial information and information on payments to service providers.
3. Assets held for investment.
4. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Kyle Stallman, who is a representative of the plan administrator, at 2700 Trumbull Avenue, Detroit, MI 48216, and phone number, 313-964-2400. The charge to cover copying costs will be $2.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan: 2700 Trumbull Avenue, Detroit, MI 48216, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

For MCTWF Retirees Plan

This is a summary of the annual report of the MCTWF Retirees Plan, a health, dental, vision and death benefits plan (Employer Identification Number 38-1328578, Plan Number 502), for the plan year 04/01/2022 through 03/31/2023. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $51,419,700 as of the end of plan year, compared to $55,352,283 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of ($3,932,583). This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $5,634,542 including employer contributions of $5,697,962, employee contributions of $3,153,925, earnings from investments of ($3,219,826), and other income of $2,481. Plan expenses were $9,567,125. These expenses included $737,400 in administrative expenses and $8,829,725 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report.
2. Financial information and information on payments to service providers.
3. Assets held for investment.
4. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Kyle Stallman, who is a representative of the plan administrator, at 2700 Trumbull Avenue, Detroit, MI 48216, and phone number, 313-964-2400. The charge to cover copying costs will be $2.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan: 2700 Trumbull Avenue, Detroit, MI 48216, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

PART 21: COVID-19 RESPONSE - MCTWF ACTIVES PLAN & MCTWF RETIREES PLAN

The Official End to the Pandemic Means Changes for MCTWF Benefit Plans (Spring 2023)
The United States Congress has passed a declaration to end the COVID-19 National Emergency (NE) on April 10, 2023, and end the Public Health Emergency (PHE) on May 11, 2023. This means all benefits and Fund time-period requirements that were mandated because of COVID-19 due to the emergencies declared over the course of the last three years, will end 60 days following May 11, 2023.

All MCTWF benefits and time period requirements will be restored back to the original benefit/requirements on July 11, 2023.

What does this mean?

COVID-19 Testing and Treatment

- Since February 4, 2020, COVID-19 testing has been covered with no member cost share by presenting your BCBS ID card at the hospital or doctor's office or your MCTWF Networks card at the pharmacy. Since January 15, 2022, at-home COVID-19 tests have been covered with no member cost share by presenting your MCTWF Networks ID card at the pharmacy as well as reimbursement of the personal purchases of at-home tests up to the maximum number of at-home testing kits allowed per month. **Effective July 11, 2023,** members will be billed applicable deductible and/or coinsurance cost share in accordance with their MCTWF bene no longer be covered under the pharmacy benefit and will no longer be reimbursed if you purchase the COVID-19 at-home test kits. fit plan for covered COVID-19 testing that is done at the hospital, doctors office or pharmacy. Also, **effective July 11, 2023**, at-home COVID-19 tests will
- Since March 4, 2020, medically necessary services to evaluate the need for and administer the tests were provided at no member cost share. **Effective July 11, 2023**, MCTWF members will be responsible for any deductibles, coinsurances, copayments, or charges, as required by their MCTWF benefit plan, for dates of services July 11, 2023 and after.
- Since March 18, 2020, MCTWF has paid the entire cost for treatment of COVID-19 with no member cost share. **Effective July 11, 2023**, members will be responsible for any deductibles, coinsurances, copayments, or charges as required by your MCTWF benefit plan, for dates of services July 11, 2023, and after.

COVID-19 Vaccine Coverage
As compared with the seasonal flu vaccine, eligible MCTWF members are covered in full for the cost of the COVID-19 vaccination under either their medical or prescription drug benefits, thereby expanding access to COVID-19 vaccine administered by local in-network retail pharmacies, when available. COVID-19 vaccines, and boosters as recommended by the Centers for Disease Control and Prevention (CDC), will continue to be covered in full with no member cost share if the vaccine is obtained at an in-network provider or pharmacy for all members that have MCTWF medical and pharmacy benefits.

Telehealth Benefits
During the pandemic, limited availability of primary care physician appointments, and greater concern about contagion in the doctor's office, made it necessary to encourage telehealth visits to healthcare providers.
MCTWF members receive telehealth benefits in two ways:

- The MDLIVE service, which provides telehealth consultations with $0 copay. Even with the pandemic ending, MCTWF will continue the $0 copay through March of 2024.
- MCTWF's telehealth benefit was expanded in 2020 to include eligible providers outside of the MDLIVE network. This expanded benefit was provided with no member cost-share (i.e., no deductible, copay, or coinsurance charge) for the duration of the health emergencies. Now that the emergencies have ended, MCTWF members will be responsible for applicable copays, deductibles, or other charges, as required by their MCTWF benefit plans, for dates of services July 11, 2023, and after.

Weekly Accident and Sickness Benefits

Since March 18, 2020, MCTWF members, whose MCTWF benefit plan included Weekly Accident and Sickness Benefits, and who were diagnosed with COVID-19, were automatically eligible for short-term disability commencing on the 8th day of the disability, after completing proper paperwork.

Also, effective March 18, 2020, any eligible participant who was directed by a qualified health care professional or public health agency to self-quarantine in connection with COVID-19 was 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, upon completing proper paperwork.

Effective July 11, 2023, and after, a COVID-19 diagnosis does not automatically mean a participant will qualify for short term disability. A range of health factors will be reviewed before Weekly Accident and Sickness Benefits can be approved.

COBRA Continuation Coverage

In April 2020, the U.S. Department of Labor, Internal Revenue Service and Department of Treasury delayed certain ERISA and COBRA-specific timeframes for employee benefit plans, participants and beneficiaries impacted by the COVID-19 pandemic.

The Final Rule established a new time convention beginning with the start of the COVID-19 National Emergency (March 1, 2020) and ending 60 days after the end of the National Emergency calling this date the "Outbreak Period." Employee benefit plans subject to ERISA and/or the Internal Revenue Code were required to disregard notice and payment deadlines occurring during the Outbreak Period, including:

- 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).

The "pause" on COBRA payments and timeframes, along with the time period for HIPAA special enrollments, ends with the declaration of the end to the pandemic. **For MCTWF members, all COBRA elections, payments, and other extended timeframes will revert back to pre-pandemic deadlines on July 11, 2023.**

Extension of Certain Timeframes

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, were ordered to disregard "certain timeframes" during the "Outbreak Period" running from March 1, 2020 until sixty (60) days after the announced end of the National Emergency. Affected time frames included 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 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.

Effective July 11, 2023, all timeframes will revert back to their original deadlines prior to the pandemic.

Details for all pre-pandemic required time frames can be found in the MCTWF Summary Plan Description Booklet mailed to all MCTWF members in June of 2022. It can also be viewed on the homepage of the MCTWF public website at www.mctwf.org.

Questions regarding benefit changes can be directed to MCTWF Member Services, available Monday through Friday, 8:30 a.m. to 5:45 p.m. at (313) 964-2400 or Toll Free at (800) 572-7687.

PART 22: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

HIPAA Notice of Privacy Practices (Summer/Fall 2023)
This notice describes how medical information about you may be used and disclosed by the Michigan Conference of Teamsters Welfare Fund (MCTWF) and how you can obtain access to this information. Please review it carefully. A complete copy of your privacy rights can be found on our website at www.mctwf.org. Select the Information tab and choose HIPAA Privacy Rule.

YOUR RIGHTS
You have the right to:
Obtain an electronic or paper copy of your medical record

- You can ask to see or obtain an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost- based fee.

Request to correct your medical record

- You can ask us to correct health information about you which you believe is incorrect or incomplete. Ask us how to do this.
- We may deny your request, but we will provide you with an explanation 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.

Request that we limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. The request may be denied if failure to provide the information may affect your care.
- You can ask us not to share information regarding your out- of-pocket payment for service or healthcare with your health insurer. We will only share information for which we are legally obligated to do so.

Request 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 will provide one accounting a year free of charge, but will assess a
reasonable, cost- based fee for subsequent requests within the same 12-month period.

Obtain a copy of this privacy notice

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

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information on your behalf.
- We will verify that the person, or entity named, has this authority to act on your behalf before we take any action.

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

- Whether to share information with your family, close friends, or others involved in your care.
- Whether to share information in a disaster relief situation.
- Whether to include your information in a hospital directory.

If you are unable to communicate your preference, we may share your information if we believe it is in the best interest of your healthcare treatment.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

Healthcare treatment

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

Bill for your services

We can use and share your health information to bill and obtain payment from health plans or other entities.

Comply with the law

We will share information about you if required by federal, state, or local law, including agencies that monitor our compliance with privacy laws.

Respond to organ and tissue donation requests

Under limited circumstances, we can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

Under limited circumstances, we can share health information with a coroner, medical examiner, or funeral director when an individual dies.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will inform you 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 request in writing that we release the information requested. You may cancel your authorization at any time by submitting a written termination notice.

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

This Notice applies to all affiliates, employees, agents, and community partners of the Michigan Conference of Teamsters Welfare Fund.

CHANGES TO THE TERMS OF THIS NOTICE:
MCTWF may modify the terms of this notice at its discretion. The modifications will apply to all of the Protected Health Information we have on file for you, and the changes will apply to all information we have about you. The revised notice will be available on our web site, and we will also mail a copy to you at your address of record, unless otherwise directed.
Privacy Officer: Gail Wilson
(313) 964-2400 ext. 202
gwilson@mctwf.org

This notice was updated August 2023 and is valid until any additional updates are completed.

The Michigan Conference of Teamsters Welfare Fund
(313) 964-2400 or toll-free (800) 572-7687
2700 Trumbull Avenue, Detroit, Michigan 48216
www.mctwf.org

PART 23: IMPORTANT DEFINITIONS

Date of Service Definition (Winter-Spring 2024)
What happens when visiting the doctor, picking up a prescription, annual eye exam, etc.?

Each one of those activities has a recording of the event or date of service, and it's important to be mindful of those dates.

The date of service is the specific time, day, month, and year in which a patient has received medical treatment(s), healthcare services, medical equipment (each monthly charge or purchase), or a pharmacy prescription fill or refill.

It is recorded for billing purposes as an item in the patient's medical record. MCTWF bases reimbursement or payment on the date of service, along with other billing factors.

For example, the date of service on a prescription is not when it is picked up, the date the prescription is written, or the date the prescription is electronically sent or presented to the pharmacist. The actual date of service is the date the prescription

was issued. In most cases, that is the day the pharmacy actually fills the prescription. If a patient fails to pick up a prescription, in a timely manner, the prescription item typically would be restocked, and the insurance claim would be cancelled.

Please be cognizant of the date of service on all prescriptions or services. If a patient is not covered on the date of service, benefits will not be allowed and you will be responsible for full payment of the service.