Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, Michigan 48216-1296
313-964-2400 ■ 800-572-7687
www.mctwf.org

Compilation of Messenger Notifications

Summer 2022

The Messenger is a publication that is used to notify you of changes to your benefit package. Such notifications, in combination with your Summary Plan Description (SPD) booklet and Schedule of Benefits, form your complete SPD. 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, 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. If you see "NA" or Not Applicable in place of a page number in the Table of Contents, that means there are no updates to that section of SPD at the current time.

July 2022

Compilation of Messenger Notifications
Summer 2022

TABLE OF CONTENTS

*An asterisk in place of a page number in this Table of Contents means there are no updates to that section of SPD since the publication of the new edition, dated April 2022.

July 2022

INTRODUCTION – MCTWF ACTIVES PLAN AND 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.

MCTWF COVID-19 PANDEMIC RESPONSE

No current updates at this time. Please refer to the SPD.

GENERAL EXCLUSIONS/LIMITATIONS – MCTWF ACTIVES AND MCTWF RETIREES PLANS

No current updates at this time. Please refer to the SPD.

ELIGIBILITY – MCTWF ACTIVES PLAN

No current updates at this time. Please refer to the SPD.

COBRA CONTINUATION OF COVERAGE

No current updates at this time. Please refer to the SPD.

ELIGIBILITY –MCTWF RETIREES PLAN

No current updates at this time. Please refer to the SPD.

ELIGIBILITY –MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

No current updates at this time. Please refer to the SPD.

MEDICAL BENEFITS – MCTWF ACTIVES PLAN AND 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 have paid if the services had been obtained from an urgent care clinic. Accordingly, both the facility and physician bills will

be payable by the patient based on discounted charges rather than the full charges and, in addition, the physician bills will be reduced by the Fund's payment at the urgent care rate for those services. For conditions that require medical attention and cannot wait for an appointment with your physician, but are not "emergent," treatment should be sought from an urgent care center.

All emergency room claims incurred by individuals 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.

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.

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.

DENTAL BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

No current updates at this time. Please refer to the SPD.

VISION BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

No current updates at this time. Please refer to the SPD.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – MCTWF ACTIVES PLAN

No current updates at this time. Please refer to the SPD.

DEATH BENEFITS – MCTWF ACTIVES PLAN

No current updates at this time. Please refer to the SPD.

HOW TO FILE A CLAIM – MCTWF ACTIVES PLAN AND 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 health care 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.

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

No current updates at this time. Please refer to the SPD.

COORDINATION OF BENEFITS – MCTWF ACTIVES PLAN AND MCTWF RETIREES PLAN

No current updates at this time. Please refer to the SPD.

YOUR RIGHTS UNDER ERISA – MCTWF ACTIVES PLAN AND 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.

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

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.