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# Compilation of Messenger Notifications
# Summer 2022 – Fall 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 to Fall 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.

*November 2022*

**Compilation of Messenger Notifications**
**Summer 2022 – Fall 2022**

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November 2022

## 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.

## 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 Compulsive 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.

## 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.

## 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**

## 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 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.

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

### 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.

Michigan Conference of Teamsters Welfare Fund

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.