Michigan Conference of Teamsters Welfare Fund

Schedule of Benefits
Benefit Package 1074

Date Inquired About: 11/5/2020
Today's Date: 11/5/2020

Effective January 2020

Michigan Conference of Teamsters Welfare Fund (MCTWF)
Benefit Package 1074
SCHEDULE OF BENEFITS

New Key 2d Medical Benefit	BCBS PPO Network	Non-BCBS PPO Network
Annual Deductible	$300 per individual $600 per family	$600 per individual $1,200 per family
Annual Out of Pocket Maximum includes medical copay and coinsurance amounts. MCTWF complies with the Affordable Care Act out-of-pocket cost limits*	$1,500 per individual in excess of deductible $3,000 per family in excess of deductible	$3,000 per individual in excess of deductible $6,000 per family in excess of deductible
In-Patient Hospital Expenses	Covered 85%** of CC after $250 copay subject to deductible for up to 365 days semi-private room or private room if medically necessary	Covered 75%** of MAB after $250 copay subject to deductible for up to 365 days semi-private room or private room if medically necessary
Hospital Emergency Expenses (must meet criteria)	Covered 100% of CC after $125** copay (waived if admitted)	Covered 100% of CC after $125** copay (waived if admitted)
Mental Health & Substance Use Disorder Benefits (must receive prior authorization for inpatient services by calling BCBS at 800-762-2382)	**Inpatient Hospital:**Covered 85%** of CC after $250 copay per admission subject to deductible **Inpatient Physician:**Covered 85%** of CC subject to deductible **Outpatient Physician:**$25** copay	**Inpatient Hospital:**Covered 75%** of MAB after $250 copay per admission subject to deductible **Inpatient Physician:**Covered 75%** of MAB subject to deductible **Outpatient Physician:**Covered 70%** of MAB subject to deductible
Surgical Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Specified Organ Transplant Program Expenses	Covered 100% of CC. Must use a designated facility.	Covered 100% of CC. Must use a designated facility.
Maternity Expenses Pre/Post Natal Delivery	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Anesthesia Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Ambulance Expenses Ground/Air/Water	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
X-ray and Diagnostic Testing Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Laboratory Expenses Fluids/Pathology/Diagnostic Tests	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Physician Charges Inpatient Outpatient Primary Care Visit Outpatient Specialist Visit Outpatient Urgent Care Visit MDLIVE Telehealth Consultation	Covered 85%** of CC subject to deductible $25** copay $50** copay $55** copay $10** copay	Covered 75%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Covered 70%** of MAB subject to deductible Not Covered
Wellness Benefit Physical / GYN Exam / Well Child Exam	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered 100% of CC Deductible & coinsurance waived	Covered 75%** of MAB subject to deductible
Injection Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Chiropractic Expenses	24 spinal manipulations per person annually covered 80% of CC. One mechanical traction per day only with spinal manipulation covered under *Physical, Speech & Occupational Therapy Expenses*. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under *Physician Charges - Outpatient/Office Visit.*	24 spinal manipulations per person annually covered 70% of MAB. One mechanical traction per day only with spinal manipulation covered under *Physical, Speech & Occupational Therapy Expenses*. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under *Physician Charges - Outpatient/Office Visit.*
Hearing Aid Expenses	Covered 85%** of CC subject to deductible, up to $1,500 per person, per ear every 2 years	Covered 85%** of MAB subject to deductible, up to $1,500 per person, per ear every 2 years
Outpatient Cancer Treatment (e.g. chemotherapy & radiation therapy)	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible
Physical, Speech & Occupational Therapy Expenses	Covered 85%** of CC subject to deductible	Covered 75%** of MAB subject to deductible

New Key 2d Medical Benefit	BCBS PPO Network	Non-BCBS PPO Network
Home Health Care Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Skilled Nursing Facility Expenses	85%** eligible expenses subject to deductible for room and board and other medical services up to 730 days reduced by 2 times the number of days in hospital.	85%** eligible expenses subject to deductible for room and board and other medical services up to 730 days reduced by 2 times the number of days in hospital.
Hospice Care Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Durable Medical Equipment and Medical Supplies Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of scheduled amount subject to deductible
Prosthetic Devices and Orthotics Expenses	Covered 85%** of CC subject to deductible	Covered 85%** of MAB subject to deductible
Survivor Health Benefits	Provides up to 36 months of free medical and prescription drug coverage for eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Coverage will mirror the benefits provided to the deceased participant's MCTWF participating group.	Provides up to 36 months of free medical and prescription drug coverage for eligible spouses and dependent children of participants who die while actively covered under a MCTWF medical benefits package. Coverage will mirror the benefits provided to the deceased participant's MCTWF participating group.

New Rx2 Prescription Drug Benefit	Caremark Pharmacy Network			
	Covered in full after the below applicable copay at a participating retail or mail order pharmacy.			
	Retail & Mail Up to 34 days	Retail 90 & Mail 35 - 60 days	Retail 90 61 - 90 days	Mail 61 - 90 days
Generic	$10 copay	$20 copay	$30 copay	$20 copay
Preferred Brand	$20 copay	$40 copay	$60 copay	$45 copay
Non-Preferred Brand	$35 copay	$70 copay	$105 copay	$80 copay

Dental Benefit	DNoA Preferred Network	Non- DNoA Preferred Network
Dental Package 2	**Dental:** Class I covered in full; Class II 100% after deductible; Class III 85% of CC after deductible. Class II & Class III $50 individual $100 family annual deductible. Annual maximum $1,500 per person. **Orthodontic:** None	**Dental:** Class I 100% of MAB; Class II 100% of CC after deductible; Class III 85% of MAB after deductible. Class II & Class III $50 individual $100 family annual deductible. Annual maximum $1,500 per person. **Orthodontic:** None

Standard Vision Benefit	EyeMed Vision Network	Non-EyeMed Vision Network
Vision	One exam and one vision correction option[1] per person per calendar year. Exam 100% of CC. Frames covered up to retail value of $150, you are responsible for any charges in excess after a 20% discount. 100% of CC for pair of clear plastic single, bifocal, trifocal or lenticular lenses. 100% of CC for progressive lenses after a copay of $42 for Standard lenses, $72 for Premium Tier 1 lenses, $82 for Premium Tier 2 lenses, $107 for Premium Tier 3 lenses, or $42 plus 80% of charges less $120 allowance for Premium Tier 4 lenses. 100% of CC per pair of polycarbonate lenses under age 19. Up to $120 for contact lenses; you are responsible for any charges in excess after a 15% discount for conventional contact lenses (no discount for disposable contact lenses,). $20 additional contact lens allowance when lenses are purchased through contactsdirect.com. 100% of CC for contact lens fitting; you are responsible up to $40 for standard contact lens fitting and follow-up, or for the retail price less 10% for premium contacts lens fitting and follow-up. Up to $250 per eye per lifetime for laser vision correction (Lasik or PRK) from U.S. Laser Network; you are responsible for any charges in excess after a 15% discount of CC or 5% off the promotional price (whichever is lower). [1] A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.	One exam and one vision correction option[1] per person per calendar year. Exam up to $50. Frames up to $75. Up to $50 for pair of clear plastic single lenses, up to $60 for pair of bifocal lenses, up to $70 for pair of trifocal lenses, and up to $70 for pair of lenticular lenses. No coverage for progressive lenses. Up to $80 for contact lenses. No coverage for contact lens fitting. Up to $250 per eye per lifetime for laser vision correction. [1] A vision correction option is defined as either (a) one pair of lenses and frames, whether purchased together or separately, (b) contact lenses and fitting, or (c) laser vision correction for one or both eyes. Note: Coverage for one such annual vision option cannot be later replaced with coverage for another vision option.

Other Benefit(s)	Coverage
Weekly Accident & Sickness Benefit (participant only)	$225 per week for a maximum of 26 weeks. Payable on the first day for an accident or the 8th day for illness after the last day worked. Family coverage continues while collecting weekly benefit.

Other Benefit(s)	Coverage
Death Benefit Participant Spouse Children (Birth up to age 26)	 $20,000 $3,000 $1,500
Accidental Death and Dismemberment (AD&D) Benefit (participant only)	$20,000 Maximum
Benefit Bank Weeks	Receive 6 benefit bank weeks for the period of 04/01/2018 through 3/31/2021.***

CC (Contracted Charges) means the agreed upon fees between MCTWF and in-network providers.

MAB (Maximum Allowable Benefit) means the portion of the amount billed by an out-of-network provider that has been established as the benefit package maximum payable amount, subject to deductible, coinsurance and co-payments.

* In accordance with the Affordable Care Act, effective January 1, 2017, all MCTWF Actives Plan medical and prescription drug benefits combined in-network out-of-pocket costs are subject to calendar year limits. Out-of-pocket costs refer to deductibles, copay and coinsurance amounts (but not contribution payments, or out-of-network cost-sharing or balance bill payments). Once a calendar year limit is reached, coverage must be provided for the balance of the year without further out-of-pocket costs for in-network medical and prescription drug benefits. The limits for 2020 are $8,200 per individual and $16,400 per family member accumulations toward these statutory out-of-pocket cost limits are tracked on each MCTWF Explanation of Benefits (EOB) form and in each MCTWF Participant Portal account.

** The co-payments and/or coinsurance payments for these services apply toward the annual out-of-pocket maximum.

*** Participant receives the noted 6 weeks except in cases where a different arrangement was approved by MCTWF, or the participant is contributed on under a MCTWF benefit package with seasonal eligibility requirements, in which case they do not receive benefit bank weeks.

Eligibility for auto-related accidental injuries or illnesses under your MCTWF benefit package will be available only to the extent that claims resulting from the accident are in excess of the greater of (1) the required insurance coverage or other financial protection required under applicable state law, or (2) the benefit limits of any other insurance under which the individual is entitled to coverage. MCTWF will provide benefits pursuant to a signed *MCTWF Assignment, Subrogation and Reimbursement Agreement*, contingent upon the submission of proof that benefits have been exhausted through the auto carrier and/or other insurance available. MCTWF does not provide Qualified Health Coverage.

If you are the operator or occupant of a rental vehicle and other medical coverage is available, no MCTWF benefits will be paid for auto-related accidental injuries or illnesses.

This Schedule of Benefits is not a full statement of covered services under your benefit package. As a general rule, all procedures or services not deemed experimental by the medical community are covered. Contact MCTWF's Member Services Call Center for any benefit questions you may have.

Michigan Conference of Teamsters Welfare Fund
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