Michigan Conference of Teamsters Welfare Fund

Schedule of Benefits
Benefit Package 1112

Date Inquired About: 7/16/2019
Today's Date: 7/16/2019

Effective May 2019

Michigan Conference of Teamsters Welfare Fund (MCTWF)
Benefit Package 1112
SCHEDULE OF BENEFITS

[illegible]	[illegible]	[illegible]
Outpatient Cancer Treatment (e.g. chemotherapy & radiation therapy)	Covered in full Copayment and coinsurance waived	100% of MAB Coinsurance waived
Annual Deductible	None	None
Annual Out of Pocket Maximum includes medical copay and coinsurance amounts. MCTWF complies with the Affordable Care Act out-of-pocket cost limits*	$2,000 per family	$4,000 per family
In-Patient Hospital Expenses	Covered 100% of CC after $250 copay for up to 365 days semi-private room or private room if medically necessary	Covered 90%** of MAB after $250 copay 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 $75** copay (waived if admitted)	Covered 100% of MAB after $75** 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 in full after $250 copay per admission. **Inpatient Physician:**Covered in full **Outpatient Physician:**$15** copay	**Inpatient Hospital:**Covered 100% of MAB after $250 copay per admission. **Inpatient Physician:**Covered 80%** of MAB **Outpatient Physician:**Covered 60%** of MAB
Surgical Expenses	Covered 100% of CC	Covered 90%** of MAB
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 100% of CC	Covered 90%** of MAB
Anesthesia Expenses	Covered 100% of CC	Covered 90%** of MAB
Ambulance Expenses Ground/Air/Water	Covered 100% of CC	Covered 100% MAB
X-ray and Diagnostic Testing Expenses	Covered 100% of CC	Covered 90%** of MAB
Laboratory Expenses Fluids, Pathology/Diagnostic Tests	Covered 100% of CC	Covered 90%** of MAB
Physician Charges Inpatient Outpatient Primary Care Visit Outpatient Specialist Visit Outpatient Urgent Care Visit MDLIVE Telehealth Consultation	Covered 100% of CC $15** copay $30** copay $35** copay $10** copay	Covered 80%** of MAB Covered 60%** of MAB Covered 60%** of MAB Covered 60%** of MAB Not Covered
Wellness Benefit Physical / GYN Exam Well Child Exam	Covered 100% of CC	Covered 60%** of MAB
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered 100% of CC	Covered 90%** of MAB
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered 100% of CC	Covered 80%** of MAB
Injection Expenses	Covered 90%** of CC	Covered 80%** of MAB
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 100% of CC, up to $1,500 per person, per ear every 2 years	Covered 100% of MAB, up to $1,500 per person, per ear every 2 years
Outpatient Cancer Treatment (e.g. chemotherapy & radiation therapy)	Covered in full Copayment and coinsurance waived	100% of MAB Coinsurance waived
Physical, Speech & Occupational Therapy Expenses	Covered 75%** of CC	Covered 65%** of MAB
Home Health Care Expenses	Covered 90%** of CC	Covered 90%** of MAB

Skilled Nursing Facility Expenses	100% eligible expenses for room and board and other medical services up to 730 days reduced by 2 times the number of days in hospital.	100% eligible expenses 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 100% of CC	Covered 100% of MAB
Durable Medical Equipment and Medical Supplies Expenses	Covered 90%** of CC	Covered 90%** of MAB
Prosthetic Devices and Orthotics Expenses	Covered 75%** of CC	Covered 75%** of MAB
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.

	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	$5 copay	$10 copay	$15 copay	$10 copay
Preferred Brand	$15 copay	$30 copay	$45 copay	$35 copay
Non-Preferred Brand	$30 copay	$60 copay	$90 copay	$70 copay

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 frame , 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.

Weekly Disability Income Benefit (This benefit is not available until April 2016) (participant only)	$250 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.
Total & Permanent Disability (TPD) Benefit (participant only)	$250 per month. $20,000 maximum benefit over an 80-month period.
Death Benefit Participant Spouse Children (Birth up to age 26)	 $30,000 $3,000 $1,500
Accidental Death and Dismemberment (AD&D) Benefit (participant only)	$30,000 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 2019 are $7,900 per individual and $15,800 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.

If you reside in the State of Michigan, no benefits will be paid under your MCTWF benefit package for auto-related accidental injuries or illnesses based upon Michigan's No-Fault automobile insurance law [providing for comprehensive health care benefits to any person(s) suffering an accidental injury or illness as a result of an automobile accident in Michigan or those who are covered by Michigan No-Fault automobile insurance and suffer an accidental injury or illness in an out-of-state (but within the United States, its territories and possessions or in Canada) automobile-related accident.]

If you reside outside the State of Michigan, no benefits will be paid under your MCTWF benefit package for auto-related accidental injuries or illnesses if such benefits are payable or required to be covered under other insurance or applicable state law. If your auto-related accidental injury or illness is not covered under Michigan's No-Fault automobile insurance law or other similar No-Fault state laws, MCTWF will provide benefits pursuant to a signed MCTWF benefit package Assignment, Subrogation and Reimbursement Agreement, contingent upon the submission of proof that benefits have been exhausted through the automobile carrier.

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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(313) 964-2400 or (800) 572-7687
Alternative Outage Number (800) 482-2219
www.mctwf.org