Michigan Conference of Teamsters Welfare Fund
SCHEDULE OF BENEFITS
Benefit Package Comparison

Medical Benefit	Benefit Package 1114 In-Network New Key 1b	Benefit Package 1471 In-Network New Key 3a
Annual Deductible	$100 per individual $200 per family	$500 per individual $1,500 per family
Annual Out of Pocket Coinsurance Maximum includes medical copay and coinsurance amounts. MCTWF complies with the Affordable Care Act out-of-pocket cost limits*	$1,000 per individual in excess of deductible $2,000 per family in excess of deductible	$2,500 per individual in excess of deductible $5,000 per family in excess of deductible
In-Patient Hospital Expenses	Covered 90%** of CC after $250 copayment subject to deductible for up to 365 days semi-private room or private room if medically necessary	Covered 80%** of CC 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 $75** copay (waived if admitted)	Covered 100% of CC after $125** copay (waived if admitted)
Mental Health & Substance Abuse Benefits (must receive prior authorization for inpatient services by calling BCBS at 800-762-2382)	**Inpatient Hospital:**Covered 90%** of CC after $250 copay per admission subject to deductible **Inpatient Physician:**Covered 90%** of CC subject to deductible **Outpatient Physician:**$15** copay	**Inpatient Hospital:** Covered 80%** of CC subject to deductible **Inpatient Physician:** Covered 80%** of CC subject to deductible **Outpatient Physician:**$25** copay
Surgical Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC 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 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Anesthesia Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Ambulance Expenses Ground/Air/Water	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
X-ray and Diagnostic Testing Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Laboratory Expenses Fluids/Pathology/Diagnostic Tests	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Physician Charges Inpatient Outpatient Primary Care Visit Outpatient Specialist Visit Outpatient Urgent Care Visit MDLIVE Telehealth Consultation	Covered 90%** of CC subject to deductible $15** copay $30** copay $35** copay $10** copay	Covered 80%** of CC subject to deductible $25** copay $50** copay $55** copay $10** copay
Wellness Benefit Physical / GYN Exam / Well Child Exam	Covered 100% of CC Deductible & coinsurance waived	Covered 100% of CC Deductible & coinsurance waived
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered 100% of CC Deductible & coinsurance waived	Covered 100% of CC Deductible & coinsurance waived
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered 100% of CC Deductible & coinsurance waived	Covered 100% of CC Deductible & coinsurance waived
Injection Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC 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 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*.
Hearing Aid Expenses	Covered 90%** of CC subject to deductible, up to $1,500 per person, per ear every 2 years	Covered 80%** of CC subject to deductible, 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	Covered 80%** of CC subject to deductible
Physical, Speech & Occupational Therapy Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Home Health Care Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible

Medical Benefit	Benefit Package 1114 In-Network New Key 1b	Benefit Package 1471 In-Network New Key 3a
Skilled Nursing Facility Expenses	90%** 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.	80%** 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 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Durable Medical Equipment and Medical Supplies Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC subject to deductible
Prosthetic Devices and Orthotics Expenses	Covered 90%** of CC subject to deductible	Covered 80%** of CC 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.
Prescription Drug Benefit	**New Rx1**	**New Rx2**
Prescription Drug	**Retail & Mail Up to 34 days** - Generic $5 copay, Preferred Brand $15 copay and Non-Preferred Brand $30 copay **Retail 90 & Mail 35-60 days** - Generic $10 copay, Preferred Brand $30 copay and Non-Preferred Brand $60 copay **Retail 90 61-90 days** - Generic $15 copay, Preferred Brand $45 copay and Non-Preferred Brand $90 copay **Mail 61-90 days** - Generic $10 copay, Preferred Brand $35 copay and Non-Preferred Brand $70 copay	**Retail & Mail Up to 34 days** - Generic $10 copay, Preferred Brand $20 copay and Non-Preferred Brand $35 copay **Retail 90 & Mail 35-60 days** - Generic $20 copay, Preferred Brand $40 copay and Non-Preferred Brand $70 copay **Retail 90 61-90 days** - Generic $30 copay, Preferred Brand $60 copay and Non-Preferred Brand $105 copay **Mail 61-90 days** - Generic $20 copay, Preferred Brand $45 copay and Non-Preferred Brand $80 copay
Standard Vision Benefit	**Standard Benefit**	**Standard Benefit**
Vision	**EyeMed Vision Network** 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. **Non-EyeMed Vision Network** 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	**EyeMed Vision Network** 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. **Non-EyeMed Vision Network** 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

Standard Vision Benefit	Standard Benefit	Standard Benefit
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Other Benefit(s)		
Weekly Accident & Sickness Benefit (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.	N/A
Total & Permanent Disability Benefit (participant only)	$250 per month. $20,000 maximum benefit over an 80-month period.	N/A
Death Benefit Participant Spouse Children (Birth up to age 26)	 $30,000 $3,000 $1,500	N/A
Accidental Death and Dismemberment Benefit (participant only)	$30,000 Maximum	N/A
Benefit Bank Weeks	Receive 6 benefit bank weeks for the period of 04/01/2021 through 3/31/2024.***	Receive 6 benefit bank weeks for the period of 04/01/2021 through 3/31/2024.***

Benefit Package 1114

* 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 2022 are $8,700 per individual and $17,400 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.

Benefit Package 1471

* 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 2022 are $8,700 per individual and $17,400 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.

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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 Plan maximum payable amount, subject to deductible, coinsurance and co-payments.

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 Plan. As a general rule, all procedures or services not deemed experimental by the medical community are covered. Contact MCTWF's Customer Communications Department for any benefit questions you may have.

Michigan Conference of Teamsters Welfare Fund
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Detroit, Michigan 48216

(313) 964-2400 or (800) 572-7687
www.mctwf.org

MESSA
1475 Kendale Boulevard, PO Box 2560
East Lansing, MI 48826-2560
800.292.4910

2023 Rate Renewal Exclusively for Gladstone Area Schools

Quote #: 350798
MESSA Field Rep: RaeAnn Loy
Date Created: 08/03/2022

Rates Effective 01/01/2023 through 12/31/2023

Quoted Group(s): 083H - Teamsters, Admin, Support

Ancillary plans

Description	Benefits
Dental	00956-07
Diag & Prev:	80%
Basic Services:	80% (X-Rays)
Major Services:	80%
Annual Max:	$1,000
Orthodontics:	80%
Lifetime Max:	$1,300
Riders:	2 Cleanings
Plan Year:	Jan-Dec

Total Monthly Rate per
Total Monthly Rate per
Total Monthly Rate per

COBRA RATES:

The COBRA rates for this group are the same as the rates above.

The above rates are based on plans and enrollment as of 08/02/2022. Material changes in the composition of the group such as number of enrollees, definable group, eligibility requirements or plans offered may affect the final rates.

If you have any questions, please contact your MESSA Field Representative, RaeAnn Loy, at 800.292.4910.