

Michigan Conference of Teamsters Welfare Fund



Schedule of Benefits Plan 208



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Plan 208
SCHEDULE OF BENEFITS

SOA Medical Plan Benefit	BCBS PPO Network	Non-BCBS PPO Network
Aggregate Medical Lifetime Maximum	\$5,000,000 per person	\$5,000,000 per person
Annual Deductible	None	None
Annual Out of Pocket Coinsurance Maximum	\$2,000 per family	\$4,000 per family
In-Patient Hospital Expenses	Covered 100% of CC after \$250 co-payment for up to 365 days semi-private room or private room if medically necessary	Covered 90%* of MAB after \$250 co-payment 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 \$20.00 co-payment (waived if admitted)	Covered 100% of MAB after \$20.00 co-payment (waived if admitted)
Mental Health & Substance Abuse Benefits (must receive prior authorization by calling 800-457-8540)	Inpatient Hospital: 45 days*** per person per calendar year. Covered in full after \$250 copay per admission. Inpatient Physician: Covered in full up to 50 visits*** annually combined with in/outpatient mental health and substance abuse. Outpatient Physician: \$15 copay; 50 visits*** annually combined with in/outpatient mental health and substance abuse.	Inpatient Hospital: 45 days*** per person per calendar year. Covered 100% of MAB after \$250 copay per admission. Inpatient Physician: Covered 50% of MAB up to 50 visits*** annually combined with in/outpatient mental health and substance abuse. Outpatient Physician: Covered 50% of MAB up to 50 visits*** annually combined with in/outpatient mental health and substance abuse.
Surgical Expenses	Covered 100% of CC	Covered 90%* of MAB
Human Organ & Tissue Transplant Benefit	Covered 100% of scheduled amount up to \$350,000 based upon organ type. \$100,000 lifetime for follow-up.	Covered 90%* of scheduled amount up to \$350,000 based upon organ type. \$100,000 lifetime for follow-up.
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	Covered 100% of CC	Covered 60%* of MAB
Outpatient/Office Visit	\$20 co-payment	Covered 60%* of MAB
Wellness Benefit Physical / GYN Exam / Well Child Exam	Covered 100% of CC Copay waived	Covered 60%* of MAB
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered 100% of CC Copay waived	Covered 90%* of MAB
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered 100% of CC Copay waived	Covered 80%* of MAB
Injections	Covered 90%* of CC	Covered 80%* of MAB
Chiropractic Expenses	Covered 80% of CC, up to \$1,000 per person, per calendar year	Covered 70% of MAB, up to \$1,000 per person, per calendar year
Hearing Aid Expenses	Covered 100% of CC, up to \$1,000 per person, per aid every 2 years	Covered 100% of MAB, up to \$1,000 per person, per aid 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	75%* of CC	65%* of MAB

SOA Medical Plan Benefit	BCBS PPO Network	Non-BCBS PPO Network	
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 in full	Covered 100% of MAB	
Durable Medical Equipment and Medical Supplies Expenses	90%* of CC	Covered 90%* of MAB	
Prosthetic Devices and Orthotics Expenses	75%* of CC	75%* of MAB	
Temporomandibular Joint Dysfunction (TMJ) Expenses	Limited up to \$1,500 lifetime per person for diagnosis and treatment*	MAB limited up to \$1,500 lifetime per person for diagnosis and treatment*	
Pharmacy Benefit	Caremark Pharmacy Network		
Prescription Drug Rx1	<p>Participating Retail: Up to 34 day supply, covered in full after \$5 copay for generic and \$15 copay for brand name drugs. 90 day supply covered in full after \$10 copay for generic and \$30 copay for brand name drugs.</p> <p>Participating Mail Order: Up to 90 day supply. Covered in full after \$10 copay for generic and \$30 copay on brand name drugs.</p>		
Dental Benefit	Delta Dental PPO Network	Delta Dental Premier Network	Non-Delta Dental Network
Dental Plan 1	<p>Dental: Class I & II covered in full; Class III 90% of CC. Annual maximum \$2,100 per person.</p> <p>Orthodontic: 85% of CC up to \$3,500 lifetime per adult/child.</p>	<p>Dental: Class I & II covered in full; Class III 85% of CC. Annual maximum \$2,000 per person.</p> <p>Orthodontic: 85% of CC up to \$3,500 lifetime per adult/child.</p>	<p>Dental: Class I & II 100% of MAB; Class III 85% of MAB. Annual maximum \$2,000 per person.</p> <p>Orthodontic: 50% of MAB up to \$2,000 lifetime per child.</p>
Vision Benefit	DeltaVision Network	Non-DeltaVision Network	
Vision	One exam and one vision correction option per person per calendar year. Exam 100% of CC. Frames up to \$125. 100% of CC for pair of basic single, bifocal or trifocal lenses. Up to \$85 for pair progressive lenses. Up to \$20 for pair polycarbonate lenses (under age 18) in addition to basic lenses. Up to \$120 for contact lenses. Uncovered charges subject to 15% discount off provider's lowest available retail price. Up to \$250 per eye per lifetime for laser vision correction.	One exam and one vision correction option per person per calendar year. Exam up to \$50. Frames up to \$75. Up to \$50 for pair of single lenses, up to \$60 for pair of bi-focal lenses, up to \$70 for pair of trifocal lenses. Up to \$70 for pair progressive lenses. Up to \$80 for contact lenses. Up to \$250 per eye per lifetime for laser vision correction.	
Other Benefit(s)	Coverage		
Weekly Accident & Sickness Benefit (participant only)	\$500 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.		
Total & Permanent Disability (participant only)	\$250 per month. \$20,000 maximum benefit over an 80-month period.		
Death Benefit	<p>Participant \$50,000</p> <p>Spouse \$3,000</p> <p>Children (Birth up to age 19) \$1,500</p>		
Accidental Death and Dismemberment Benefit (participant only)	\$50,000 Maximum		
Benefit Bank Weeks	Receive 6 benefit bank weeks for the period of 4/1/09 through 3/31/12.**		

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.

- * The coinsurance payments for these services apply toward the 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 plan with seasonal eligibility requirements, in which case they do not receive benefit bank weeks.
- *** Each non-residential intensive outpatient day counts as one fourth of an inpatient day and each residential intensive outpatient day counts as one half of an inpatient day. All professional visits provided in connection with an approved in-hospital treatment (including inpatient, partial/day hospital and intensive outpatient with or without domiciliary component) will be covered. In addition, during the four months following discharge, or until January 1st, whichever period is shorter, up to 10 more professional visits will be covered after the 50 in/outpatient professional limit has been exhausted.

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.

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