

Michigan Conference of Teamsters Welfare Fund



Schedule of Benefits Plan 500

Date Inquired About: 1/18/2012
Today's Date: 1/18/2012

Effective November 2011



Michigan Conference of Teamsters Welfare Fund
Plan 500
SCHEDULE OF BENEFITS

Key 1b Major Medical Plan Benefit	BCBS PPO Network	Non-BCBS PPO Network
Annual Deductible	\$100 per individual \$200 per family	\$200 per individual \$400 per family
Annual Out of Pocket Coinsurance Maximum	\$1,000 per individual in excess of deductible \$2,000 per family in excess of deductible	\$2,000 per individual in excess of deductible \$4,000 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 MAB after \$250 copayment subject to deductible for up to 365 days semi-private room or private room if medically necessary
Hospital Emergency Expenses (must meet criteria)	Covered 90%* of CC after \$75** copayment (waived if admitted) subject to deductible	Covered 90%* of MAB after \$75** copayment (waived if admitted) subject to deductible
Mental Health & Substance Abuse Benefits (must receive prior authorization by calling Value Options at 800-457-8540)	Inpatient Hospital: 45 days**** per person per calendar year. Covered 90%* of CC after \$250 copayment subject to deductible. Inpatient Physician: Covered 90% of CC subject to deductible for 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 80%* of MAB after \$250 copayment subject to deductible. Inpatient Physician: Covered 80% of MAB subject to deductible for 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 90%* of CC subject to deductible	Covered 80%* 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 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Anesthesia Expenses	Covered 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Ambulance Expenses Ground/Air/Water	Covered 90%* of CC subject to deductible	Covered 90%* of MAB subject to deductible
X-ray and Diagnostic Testing Expenses	Covered 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Laboratory Expenses Fluids/Pathology/Diagnostic Tests	Covered 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Physician Charges Inpatient/Outpatient Office Visit	Covered 90%* of CC subject to deductible \$20** copayment (in lieu of coinsurance)	Covered 80%* of MAB subject to deductible
Wellness Benefit Physical / GYN Exam / Well Child Exam	Covered in full Deductible & copayment waived	Covered 80%* of MAB subject to deductible
Wellness Benefit Pap Smear Screening & Mammogram Screening	Covered in full Deductible & copayment waived	Covered 80%* of MAB subject to deductible
Wellness Benefit Child Immunization / Adult Flu Vaccination	Covered in full Deductible & copayment waived	Covered 80%* of MAB subject to deductible
Injection Expenses	Covered 90%* of CC subject to deductible	Covered 80%* 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 <i>Physical, Speech & Occupational Therapy Expenses</i> . One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under <i>Physician Charges - Outpatient/Office Visit</i> .	24 spinal manipulations per person annually covered 70% of MAB. One mechanical traction per day only with spinal manipulation covered under <i>Physical, Speech & Occupational Therapy Expenses</i> . One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor, covered under <i>Physician Charges - Outpatient/Office Visit</i> .
Hearing Aid Expenses	Covered 90%* of CC subject to deductible, up to \$1,000 per person, per aid every 2 years	Covered 90%* of MAB subject to deductible, up to \$1,000 per person, per aid every 2 years
Outpatient Cancer Treatment (e.g. chemotherapy & radiation therapy)	Covered 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Physical, Speech & Occupational Therapy Expenses	Covered 90%* of CC subject to deductible	Covered 80%* of MAB subject to deductible
Home Health Care Expenses	Covered 90%* of CC subject to deductible	Covered 90%* of MAB subject to deductible

Key 1b Major Medical Plan Benefit	BCBS PPO Network	Non-BCBS PPO Network
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.	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.
Hospice Care Expenses	Covered 90%* of CC subject to deductible	Covered 90%* of MAB subject to deductible
Durable Medical Equipment and Medical Supplies Expenses	Covered 90%* of CC subject to deductible	Covered 90%* of scheduled amount subject to deductible
Prosthetic Devices and Orthotics Expenses	Covered 90%* of CC subject to deductible	Covered 90%* of MAB subject to deductible
Pharmacy Benefit	Caremark Pharmacy Network	
Prescription Drug Rx2	<p>Participating Retail: Up to 34 day supply, covered in full after \$10 copay for generic and \$20 copay for brand name drugs. 90 day supply covered in full after \$20 copay for generic and \$40 copay for brand name drugs.</p> <p>Participating Mail Order: Up to 90 day supply. Covered in full after \$20 copay for generic and \$40 copay on brand name drugs.</p>	
Dental Benefit	DNoA Preferred Network	Non- DNoA Preferred Network
Dental Plan 2	<p>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.</p> <p>Orthodontic: None</p>	<p>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.</p> <p>Orthodontic: None</p>
Vision Benefit	VSP Choice Network	Non-VSP Choice Network
Vision	<p>One exam and one vision correction option¹ 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 per pair of progressive lenses. 100% of CC per pair polycarbonate lenses under age 19. Up to \$120 for contact lenses. 100% of CC after you pay the first \$60 for contact lenses fitting. Up to \$250 per eye per lifetime for laser vision correction. An average of 20% discount is applied to uncovered charges, excluding contact lenses and laser vision correction.¹</p> <p><small>Vision correction option is a pair of lenses plus frames, or contact lenses and fitting, or laser vision correction for one or both eyes.</small></p>	<p>One exam and one vision correction option¹ 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.¹</p> <p><small>Vision correction option is a pair of lenses plus frames, or contact lenses and fitting, or laser vision correction for one or both eyes.</small></p>
Other Benefit(s)	Coverage	
Weekly Accident & Sickness Benefit (participant only)	<p>\$225 per week for a maximum of 26 weeks.</p> <p>Payable on the first day for an accident or the 8th day for illness after the last day worked.</p> <p>Family coverage continues while collecting weekly benefit.</p>	
Death Benefit		
Participant	\$20,000	
Spouse	\$3,000	
Children (Birth up to age 26)	\$1,500	
Accidental Death and Dismemberment Benefit (participant only)	\$20,000 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.
- ** The co-payments and/or coinsurance payments for these services do not apply towards 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 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.

Michigan Conference of Teamsters Welfare Fund
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