# Michigan Conference of Teamsters Welfare Fund


# Schedule of Benefits
# Plan 475

**Effective April 2010**

# Michigan Conference of Teamsters Welfare Fund
# Retiree Medical Program Plan 475
## SCHEDULE OF BENEFITS

| Retiree Medical Program with Rider Benefit | BCBS PPO Network | Non BCBS PPO Network |
|---|---|---|
| **Annual Maximum** | $200,000 per person | $200,000 per person |
| Annual Deductible | $100 individual | $100 individual |
| Coverage/Coinsurance | 85% /15% of CC | 75%/25% of MAB* |
| Annual Out of Pocket Coinsurance Maximum | $1,000 per person in excess of deductible. | $2,000 per person in excess of deductible. |
| **In-Patient Hospital Expenses** | Covered 85%* of CC subject to deductible for up to 365 days semi-private room or private room if medically necessary | Covered 75%* of MAB subject to deductible for up to 365 days semi-private room or private room if medically necessary |
| **Hospital Emergency Expenses** (must meet criteria) | Covered 85%* of CC subject to deductible | Covered 85%* of MAB subject to deductible |
| **Mental Health & Substance Abuse Benefits** (must receive prior authorization by calling 800-457-8540) | **Inpatient Hospital:** 45 days*** per person per calendar year. Covered 85%* of CC subject to deductible. **Inpatient Physician:** Covered 85% of CC subject to deductible for up to 50 visits*** annually combined with in/outpatient mental health and substance abuse. **Outpatient Physician:** Covered at 50% subject to deductible; up to 50 visits*** annually combined with in/outpatient mental health and substance abuse**. | **Inpatient Hospital:** 45 days *** per person per calendar year. Covered 75%* MAB subject to deductible. **Inpatient Physician:** Covered 75% of MAB subject to deductible for up to 50 visits*** annually combined with in/outpatient mental health and substance abuse. **Outpatient Physician:** Covered at 50% MAB subject to deductible; up to 50 visits*** annually combined with in/outpatient mental health and substance abuse**. |
| **Surgical Expenses** | Covered 85%* of CC subject to deductible | Covered 75%* of MAB subject to deductible |
| **Human Organ & Tissue Transplant Benefit** | Covered 85%* of scheduled amount subject to deductible for up to $350,000 based upon organ type. $100,000 lifetime for follow-up. | Covered 75%* of scheduled amount subject to deductible for up to $350,000 based upon organ type. $100,000 lifetime for follow-up. |
| **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/Office Visit | Covered 85%* of CC subject to deductible | Covered 75%* of MAB subject to deductible |
| **Wellness Benefit** Physical / GYN Exam / Well Child Exam | Covered in full Deductible & copayment waived | Covered 75%* of MAB subject to deductible |
| **Wellness Benefit** Pap Smear Screening & Mammogram Screening | Covered in full Deductible & copayment waived | Covered 75%* of MAB subject to deductible |
| **Wellness Benefit** Child Immunization / Adult Flu Vaccination | Covered in full Deductible & copayment waived | Covered 75%* of MAB subject to deductible |
| **Injections** | Covered 85%* of CC subject to deductible | Covered 75%* of MAB subject to deductible |
| **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 |

| Retiree Medical Program with Rider Benefit | BCBS PPO Network | Non BCBS PPO Network |
|---|---|---|
| Hearing Aid Expenses | Covered 85%* of CC subject to deductible, up to $1,000 per person, per aid every 2 years | Covered 85%* subject to deductible, up to $1,000 per person, per aid every 2 years |
| **Physical, Speech & Occupational Therapy Expenses** | Covered 85%* of CC subject to deductible | Covered 75%* of MAB subject to deductible |
| **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 Rental 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 |
| **Temporomandibular Joint Dysfunction (TMJ) Expenses** | Covered 85%* of CC subject to deductible up to $1,500 lifetime per person for diagnosis and treatment | Covered 75%* of MAB subject to deductible up to $1,500 lifetime per person for diagnosis and treatment |

| Pharmacy Benefit | Caremark Pharmacy Network |
|---|---|
| **Prescription Drug Rx1** | **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.<br><br>**Participating Mail Order:** Up to 90 day supply. Covered in full after $10 copay for generic and $30 copay on brand name drugs. |

| Dental Benefit | Delta Dental PPO Network | Delta Dental Premier Network | Non-Delta Dental Network |
|---|---|---|---|
| **Dental Plan 2** | **Dental**: Class I covered in full; Class II 100% in excess of deductible; Class III 90% of CC in excess of deductible. Class II & Class III $50 per person and $100 per family annual deductible. Annual maximum $1,600 per person.<br>**Orthodontic:** None | **Dental**: Class I covered in full; Class II 100% in excess of deductible; Class III 85% of CC in excess of deductible. Class II & Class III $50 per person and $100 per family annual deductible. Annual maximum $1,500 per person.<br>**Orthodontic:** None | **Dental**: Class I 100% of MAB; Class II 100% of MAB in excess of deductible; Class III 85% of MAB in excess of deductible. Class II & Class III $50 per person and $100 per family annual deductible. Annual maximum $1,500 per person.<br>**Orthodontic:** None |

| 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 $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 | Coverage Information |
|---|---|
| **Member Contribution** | Contribution required; see SPD for details. |
| **Qualifying Age** | Age 57 to age 65 with certain prior plan participation requirements.<br>Age 50 to age 65 with certain prior plan participation requirements for "30-and-out Pension" participants only (excluding I&S participants who must be at least age 57). |
| **Dependent Coverage** | Coverage is provided only to your spouse under age 65 and not eligible for Medicare |

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's 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.

*** 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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