# Michigan Conference of Teamsters Welfare Fund
# Plan 173 (ADN3A)
## SUMMARY SCHEDULE OF BENEFITS

| Benefits | BCBS PPO Network | Non BCBS PPO Network |
|---|---|---|
| **SOA Medical Lifetime Maximum** | $5,000,000 per person | $5,000,000 per person |
| **Hospital Expenses** | Covered in full up to 365 days<br>$250 inpatient copay; $20 emergency copay. | 90% MAB* up to 365 days<br>$250 inpatient copay; $20 emergency copay. |
| **Basic Benefits – Annual Out-of-Pocket Coinsurance Maximum** | Not Applicable | $2,000 per family; applies to specific benefits. Refer to your SPD. |
| **Physician Surgical Expenses, Diagnostic Imaging, Laboratory Tests and Maternity Care** | Covered in full | 90% of MAB* |
| **Chiropractic** | 80% of contracted amount up to $1,000 per person per calendar year | 70% of MAB* up to $1,000 per person per calendar year |
| **Mental & Nervous Disorders and Substance Abuse Treatment** (must receive prior authorization) | **Inpatient Hospital:** 45 days per person per calendar year. Covered in full after $250 copay per admission.<br>**Inpatient Physician:** Covered in full up to 50 visits annually combined with in/out mental & nervous and substance abuse.<br>**Outpatient Physician:** $15 copay; 50 visits annually combined with in/outpatient mental & nervous and substance abuse. | **Inpatient Hospital:** 45 days per person per calendar year. 100% MAB* covered after $250 copay per admission.<br>**Inpatient Physician:** 50% MAB* covered up to 50 visits annually combined with in/out mental & nervous and substance abuse.<br>**Outpatient Physician:** 50% MAB* up to 50 visits annually combined with in/outpatient mental & nervous and substance abuse. |
| **Physicians Charges** | Inpatient: Covered in full<br>Office Visits: $20 copay | 60% of MAB*<br>Inpatient and office visits |
| **Wellness** | Covered in full; copay waived. | Reimbursement based on applicable non-wellness benefit amount |
| **Extended Benefits**<br>Includes but not limited to:<br>Injections, immunizations, etc. | $1,000,000 lifetime per person with up to $5,000 restored annually. No annual deductible; 90% of contracted amount. Annual coinsurance out-of-pocket maximum $2,000/family. | $1,000,000 lifetime per person with up to $5,000 restored annually. $100 individual, $200 family annual deductible; 80% of MAB*. Annual coinsurance out-of-pocket maximum $4,000/family. |

| Benefit | Delta Dental Premier Network | Delta Dental PPO Network | Non-Delta Dental Network |
|---|---|---|---|
| **Dental Plan 1** | **Dental**: Class I & II covered in full; Class III 85% of contracted amount. Annual maximum $2,000 per person. **Orthodontic:** 85% of contracted amount up to $3,500 lifetime per adult/child. | **Dental**: Class I & II covered in full; Class III 90% of contracted amount. Annual maximum $2,100 per person. **Orthodontic:** 85% of contracted amount up to $3,500 lifetime per adult/child. | **Dental**: Class I & II 100% of MAB*; Class III 85% of MAB*. Annual maximum $2,000 per person. **Orthodontic:** 50% of MAB* up to $2,000 lifetime per child. |

| Benefit | DeltaVision Network | Non-DeltaVision Network |
|---|---|---|
| **Optical** | One exam and one vision correction option per person per calendar year. Exam 100% of contracted amount. Frames up to $125. 100% of contracted amount for pair of single, bifocal or trifocal lenses. Up to $120 for contact lenses. 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 and up to $80 for contact lenses. Up to $250 per eye per lifetime for laser vision correction |

| Benefit | Coverage | |
|---|---|---|
| **Prescription Drugs** | **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>**Participating Mail Order:** Up to 90 day supply. Covered in full after $10 copay for generic and $30 copay on brand name drugs. | |
| **Death and Accidental Death & Dismemberment (AD&D)** | Participant: $30,000 Death and up to $30,000 AD&D<br>Spouse: $3,000 Death Children (birth to 19): $1,500 Death | |
| **Weekly Accident & Sickness (participant only)** | $250 per week up to 26 weeks; benefits remain in effect while collecting. | |
| **Benefit Bank Weeks** | Receive 6 benefit bank weeks for the period of 4/1/06 through 3/31/09 | |
| **Dependent Coverage** | Medical through 18 years old. Full time student 19 through 23 years old. | |
| | Dental through 18 years old.<br>Full time student 19 through 23 years old. | Dental through 18 years old; no orthodontic after age 18. Full time student 19 through 23 years old. |

* MAB – Maximum Allowable Benefit is the portion of the amount billed by an out-of-network provider and established as the Plan's maximum payable amount subject to deductibles, coinsurance and co-payments.

This document is intended to provide brief descriptions of the most common benefits. For a comprehensive description of all benefits, please refer to your Summary Plan Description booklet, Schedule of Benefits and *Messengers* (or *Messenger* Compilation).

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