



**SOUTH LYON COMMUNITY SCHOOLS
TEAMSTERS OVERVIEW OF MEDICAL BENEFITS
EFFECTIVE JANUARY 1, 2012**

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan as indicated in the following pages.

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Deductible applies to essential and non-essential benefits <ul style="list-style-type: none"> • Individual • Family 	None None	Not Covered Not Covered	\$5,000 \$10,000	Not Covered Not Covered
Out-Of-Pocket applies to essential and non-essential benefits <ul style="list-style-type: none"> • Individual • Family 	None None	Not Covered Not Covered	None None	Not Covered Not Covered
Lifetime Maximum	Unlimited			
MEDICAL EXPENSES – ESSENTIAL				
	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Hospital-Inpatient	100%	Not Covered	100%, after deductible	Not Covered
Surgery	100%	Not Covered	100%, after deductible	Not Covered
Hospital Visits	100%	Not Covered	100%, after deductible	Not Covered
Emergency Room <ul style="list-style-type: none"> • Emergency 	100%, after \$150 co-pay (Co-pay waived if admitted)	100%, after \$150 co-pay (Co-pay waived if admitted)	100%, after a \$100 co-pay (Co-pay waived if admitted)	100%, after a \$100 co-pay (Co-pay waived if admitted)
Urgent Care <ul style="list-style-type: none"> • Illness or Accidental Injury 	100%, after \$50 co-pay	100%, after \$50 co-pay (Emergency Only)	100%, after \$50 co-pay	100%, after \$50 co-pay (Emergency Only)
Allergy Testing and Injections	100%	Not Covered	100%, after deductible	Not Covered
Ambulance	100%	100%	100%, after deductible	100%, after deductible
Anesthesia	100%	Not Covered	100%, after deductible	Not Covered

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Blood	100%	Not Covered	100%, after deductible	Not Covered
Cardiac Rehabilitation	100%	Not Covered	100%, after deductible	Not Covered
Chemotherapy	100%	Not Covered	100%, after deductible	Not Covered
Chiropractic Care <ul style="list-style-type: none"> Office Visits, Spinal Manipulation, Adjustments, Physical Therapy and X-rays (10 visits in a calendar year)	100%, after \$25 co-pay	Not Covered	100%, after deductible and \$15 co-pay	Not Covered
Consultations <ul style="list-style-type: none"> Inpatient and Outpatient Office 	100%	Not Covered	100%, after Deductible	Not Covered
	100%, after \$25 co-pay	Not Covered	100%, after \$15 co-pay	Not Covered
Contraceptives Devices IUD and diaphragms	100%	Not Covered	100%, after deductible	Not Covered
Diabetes Management Program - Outpatient	100%,	Not Covered	100%, after deductible	Not Covered
Dialysis	100%	Not Covered	100%, after deductible	Not Covered
Fertility Testing <ul style="list-style-type: none"> Counseling 	100%	Not Covered	100%, after deductible	Not Covered
	100%, after \$25 co-pay	Not Covered	100%, after \$15 co-pay	Not Covered
Home Health Care	50%	Not Covered	50%, after deductible	Not Covered
Hospice (Respite care limited to 5 days during a 30 day period) (210 days in a lifetime)	100%	Not Covered	100%	Not Covered
Implants	100%	Not Covered	100%, after deductible	Not Covered
Injections including administration of a covered medication (When an office visit is not billed)	100%	Not Covered	100%, after deductible	Not Covered

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Laboratory Testing	100%	Not Covered	100%, after deductible	Not Covered
Medical Equipment and Supplies including diabetic supplies, insulin pumps and blood glucose monitors	50%	Not Covered	50%, after deductible	Not Covered
Mental Disorders and/or Substance Abuse Expenses	100%	Not Covered	100%, after deductible	Not Covered
<ul style="list-style-type: none"> • Inpatient • Outpatient 	100%, after \$25 co-pay	Not Covered	100%, after \$15 co-pay	Not Covered
Occupational Therapy (limited to 60 visits in a calendar year combined with speech and physical therapy)	100%, after \$25 co-pay	Not Covered	100%, after deductible and \$15 co-pay	Not Covered
Office Visits including related services rendered during the physician's office visit	100%, after \$25 co-pay	Not Covered	100%, after \$15 co-pay	Not Covered
Orthotics	50%	Not Covered	50%, after deductible	Not Covered
Physical Therapy (limited to 60 visits in a calendar year combined with occupational and speech therapy)	100%, after \$25 co-pay	Not Covered	100%, after deductible and \$15 co-pay	Not Covered
Pregnancy Related Expenses-Mother	100%	Not Covered	100%, after deductible and \$15 co-pay	Not Covered
<ul style="list-style-type: none"> • Pre and Post Natal Care • Delivery 	100%	Not Covered	100%, after deductible	Not Covered

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Prescription Drugs <u>Retail</u> <ul style="list-style-type: none"> • Generic • Brand <u>Mail Order</u> <ul style="list-style-type: none"> • Generic • Brand 	<u>90-day supply</u> \$10 co-pay \$50 co-pay		<u>90-day supply</u> \$10 co-pay \$40 co-pay	
	Network	Non-Network	Network	Non-Network
Preventive Care Required preventive care as defined by PPACA including but not limited to: Immunizations, including flu shots <ul style="list-style-type: none"> • Well child care • Routine physical exams • Screening for high blood pressure • Mammogram • Screening for cervical cancer • Screening for cholesterol • Screening for diabetes • Screening for colorectal cancer NOTE: For additional information including any limitations go to the website www.uspreventiveservicestaskforce.org <ul style="list-style-type: none"> • Prostate Specific Antigen (PSA) exam and related testing 	100%	Not Covered	100%	Not Covered
	<ul style="list-style-type: none"> • Immunizations received at the local health department will be covered at the Network benefit • Flu shots will be covered at Retail stores and pharmacies as network services 			

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Prosthetic Devices (Specially designed prosthetic bras are limited to 4 in a calendar year)	50%	Not Covered	50%, after deductible	Not Covered
Radiation Therapy	100%	Not Covered	100%, after deductible	Not Covered
Skilled Nursing Facility (100 days in a calendar year)	50%	Not Covered	50%, after deductible	Not Covered
Speech Therapy (limited to 60 visits in a calendar year combined with occupational and physical therapy)	100%, after \$25 co-pay	Not Covered	100%, after deductible and \$15 co-pay	Not Covered
Transplants Human Organs (Cornea, Kidney, Skin)	100%	Not Covered	100%, after deductible	Not Covered
Transplants Bone Marrow/Stem Cell	100%	Not Covered	100%, after deductible	Not Covered
Transplants Specified Human Organs: Liver, Heart, Lung, Pancreas, Heart-Lung	(Designated Transplant Network Only) 100%	Not Covered	(Designated Transplant Network Only) 100%, after deductible	Not Covered
Weight Management for Morbid Obesity	Payment is based as service rendered (e.g. office visits will be covered as stated under the office visit listing)	Not Covered	Payment is based as service rendered (e.g. office visits will be covered as stated under the office visit listing)	Not Covered
X-rays	100%		100%, after deductible	
All Other Covered Expenses	100%	Not Covered	100%, after deductible	Not Covered

MEDICAL EXPENSES - NON-ESSENTIAL BENEFITS

	TEAMSTERS PLAN 1		TEAMSTERS PLAN 2	
	Network	Non-Network	Network	Non-Network
Transplants \$10,000 maximum for transportation, meals and lodging for patient and 1 companion (2 if the patient is a minor)	100%	Not Covered	100%, after deductible	Not Covered
Vision (eye glass frames for glasses following cataract surgery limited to \$250 in a calendar year)	100%	Not Covered	100%, after deductible	Not Covered

NOTE: Any maximums listed are applicable to all plan options. If a new plan option is elected, any amounts applied toward the maximums in the current/previous plan option will be applied to the new plan option. Plan maximums do not start over when a new plan option is elected.



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SOUTH LYON COMMUNITY SCHOOLS Dental Benefits Plan
Teamsters

Group # 9946

The Plan-at-a-Glance

PPO Networks: ADN Dental Network, Michigan Dental Plan, DenteMax

Maximum Benefits Plan year January 1 through December 31

Annual Maximum \$1500 per eligible individual for covered class I, II and III services.
 Lifetime Maximum \$1300 per eligible individual for covered class IV services

Class I Preventive Services – 75%

Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 14

Class II Restorative Services – 75%

Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch

Class III Major Services – 75%

Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months

Class IV Orthodontic Services – 75%

Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, to age 19
Comprehensive Treatment	Fixed Appliance Therapy, to age 19

Not Covered

Sealants
 Eposteal and Transosteal Implants
 TMJ/TMD Treatment
 Cosmetic Treatment

Deductible – None
 Missing Tooth Clause – None
 12 Month Billing Limitation
 Waiting Periods – None
 COB – Standard

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
 **Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding \$200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**



Michigan School Districts
EyeMed Select Plan H, Fixed Fee
100% Employer Paid -OR- Bundled With Group Medical or Dental
Option EyeMed 3

Version 4

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Vision Care Services	Member Cost	Out-of-Network
Exam with Dilatation as Necessary	\$0 Copay	\$45
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A
Frames: Any available frame at provider location	\$0 Copay; \$65 Allowance, 20% off balance over \$65	\$55
Standard Plastic Lenses		
Single Vision	\$0 Copay	\$38
Bifocal	\$0 Copay	\$60
Trifocal	\$0 Copay	\$72
Lenticular	\$0 Copay	\$108
Standard Progressive Lens**	\$0 Copay	\$60
Premium Progressive Lens**	\$0, 80% of Charge less \$120 Allowance	\$60
Lens Options:		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$0	\$14
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate - Adults	\$0	\$5
Standard Polycarbonate - Kids under 19	\$0	\$5
Standard Anti-Reflective Coating	\$45	N/A
Polarized	\$0	\$44
Photocromatic / Transitions Plastic	\$0	\$70
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses <i>(Contact lens allowance includes materials only)</i>		
Conventional	\$0 Copay; \$115 allowance, 15% off balance over \$115	\$115
Disposable	\$0 Copay; \$115 allowance, plus balance over \$115	\$115
Medically Necessary	\$0 Copay, Paid-in-Full	\$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Rate		
Subscriber	\$7.72	
Subscriber + 1	\$14.67	
Subscriber + Family	\$21.54	

All plans are based on a 48-month contract term and 48-month rate guarantee

** Standard Progressive Lens covered - fund Premium Progressive as a Standard

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid for groups domiciled in the State of MI.

Fees quoted will be valid until the 1/1/2011 plan implementation date. Date quoted: 10/25/2011.

Rates assume 100% employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York

Fidelity Security Life Policy number VC-19/VC-20, form number M-9083

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
- 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 8) Services or materials provided by any other group benefit plan providing vision care;
- 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If Michigan School Districts has chosen this benefit design, attach this document to the group application and sign here:

Signature

Date

TC10