SCHEDULE OF BENEFITS

Michigan Conference
of Teamsters Welfare Fund
Schedule of Benefits

Plan 383

July 2008

Health and welfare benefits play an important part in your life. They help you pay for doctor visits, prescription drugs, dental treatment, optical care and many other common health care needs. Your benefits also provide financial protection in the event of unexpected, catastrophic events such as hospitalization, surgery, disability or death.

Your benefits. If you are an eligible active participant, the Michigan Conference of Teamsters Welfare Fund provides you and your eligible dependents with a benefit Plan that includes important programs to help you meet your health and welfare needs.

These programs are explained in detail in the Summary Plan Description booklet. This Schedule of Benefits is part of the Summary Plan Description. You should read this Schedule with the booklet for a complete description of your benefits.

Network options. You have the option of using In-Network or Out-of-Network physicians, hospitals and dentists for your healthcare needs. In-Network physician services are provided through the Blue Cross Blue Shield (BCBS) PPO nationwide network for hospital and physician services with benefits paid at network levels. You may also use a BCBS Traditonal or MultiPlan network provider subject to non-network limitations without any balance billing exposure. Prescription drug services are provided through Caremark under their nationwide network. In-Network dental services are provided through Delta Dental of Michigan under the Delta Premier and PPO nationwide network of providers. In-Network vision services are provided through DeltaVision under their nationwide network of providers. When you receive services from a BCBS PPO, Delta Dental of Michigan or DeltaVision provider, you will experience little or no out-of-pocket expenses.

In-Network mental health and substance abuse services are provided by Value Options. All mental health and substance abuse services must first be prior authorized by calling Value Options at 800-457-8540.

When you use a provider that does not participate in the BCBS PPO or Traditional network, MultiPlan network, Delta Dental of Michigan network, Delta Vision or Value Options network, you will have higher out-of-pocket expenses and will be responsible for any amounts over and above the Plan's reimbursement.

You may visit the MCTWF's website at www.mctwf.org to link to the BCBS, MultiPlan, Delta Dental and DeltaVision websites to obtain up-to-date listings of network health care providers, hospitals, dental and vision providers

BENEFIT DETAILS

The following chart highlights the benefits provided as of August 1, 2008. Additional limitations apply for certain coverages, and prior authorization is required for certain services and equipment, so you should review this material with your Summary Plan Description booklet to learn more about your benefits. If you have questions, please contact the Customer Service Department at (313) 964-2400. You may also call toll free at (800) 572-7687.

Benefit	In-Network	Out-of-Network
Medical Benefits		
Lifetime Maximum	$2,000,000 per person all benefits combined	$2,000,000 per person all benefits combined
Major Medical Annual Deductible	$200 per individual $400 per family	$400 per Individual $800 per family
Reimbursement	85% of CC	75% of MAB
Out-of-Pocket Maximum (In exceess of deductible)	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family
Hospital Expenses Copay	85%* of CC after deductible for up to 365 days semi-private $250 inpatient copay	75%* of MAB after deductible for up to 365 days semi-private $250 inpatient copay
Hospital Emergency Benefit	85%* of CC after deductible $75 emergency copay	85% of MAB* after deductible $75 emergency copay
Ambulance Ground/Air/Water	85% of CC after deductible	85% of MAB after deductible
Physician Charges Office	$20 co-pay	75%* of MAB after deductible
Hospital Outpatient Clinic Visit	85%* of CC after deductible	75%* of MAB after deductible
Inpatient	85%* of CC after deductible	75%* of MAB after deductible
Surgical Benefits	85%* of CC after deductible	75%* of MAB after deductible
Maternity Benefits Member/Spouse only Pre/Post-Natal Delivery	85%* of CC after deductible	75%* of MAB after deductible
Anesthesia	85%* of CC after deductible	75%* of MAB after deductible
X-ray	85%* of CC after deductible	75%* of MAB after deductible
Laboratory Tests: Fluids/Pathology/ Diagnostic Tests	85%* of CC after deductible	75%* of MAB after deductible
Wellness Mammography Screening	100% of CC deductible & copay waived	75%* of MAB after deductible
Wellness Physical Exam/GYN Exam	100% of CC deductible & copay waived	75%* of MAB after deductible
Wellness Pap Smear Screening	100% of CC deductible & copay waived	75%* of MAB after deductible
Well Child Exam	100% of CC deductible & copay waived	75%* of MAB after deductible

CC means Contracted Charges as described in your SPD

MAB means Maximum Allowable Benefit Charges as described in your SPD

* The coinsurances for these services apply toward the out-of pocket maximum

Benefit	In-Network	Out-of-Network
Wellness Child Immunizations	100% of CC deductible & copay waived	75%* of MAB after deductible
Mental Health & Substance Abuse Inpatient	Requires prior authorization	
Hospital	45 days per person per calendar year covered at 85%* of CC after deductible, in addition to $250 copay.	45 days per person per calendar year covered at 75%* of MAB after deductible, in addition to $250 copay.
Physician	85% of CC up to 50 visits per year combining in/out mental health & substance abuse treatment.	75% of MAB up to 50 visits per year combining in/out mental health & substance abuse treatment.
Outpatient	100% of CC after $15 copayment up to 50 visits per year combined with in/out mental health and substance abuse treatment	50% of MABup to 50 visits per year combined in/out mental health and substance abuse treatment
Home Health Care Requires prior authorization	85%* of CC after deductible	85%* of MAB after deductible
Skilled Nursing Facility	85%* of CC after deductible for eligible expenses for room and board and other medical services	85%* of MAB after deductible for eligible expenses for room and board and other medical services
Hospice Care Requires prior authorization	85%* of CC after deductible	85%* of MAB after deductible
Chiropractic Benefits	80% of CC up to $1,000 per person per calendar year	70% of MAB up to $1,000 per person per calendar year
Hearing Aids Covered every 2 years	85%* of CC after deductible up to $1,000 per person per aid	85%* after deductible up to $1,000 per person per aid
Temporomandibular Joint Dysfunction (TMJ)	85%* of CC after deductible Up to $1,500 per person per lifetime	75%* of MAB after deductible Up to $1,500 per person per lifetime
Human Organ & Tissue Transplant Benefit	85%* of CC after deductible up to scheduled amount based upon organ type	75%* of MAB after deductible up to scheduled amount based upon organ type

Prescription Drugs

Retail	100% of CC for up to 34-day supply. Generic: $5 copay. Brand: $15 copay
90-day Retail	100% of CC for up to 90-day supply. Generic: $10 copay. Brand: $30 copay
Mail Order	100% of CC for up to 90-day supply. Generic: $10 copay. Brand: $30 copay

Benefit	In-Network Premier	In-Network PPO	Out-of-Network
Dental Benefits			
Non-Orthodontic Services Annual Maximum	$2,000 per person	$2,100 per person	$2,000 per person
Deductible Class I & II	Covered in full	Covered in full	Covered 100% of fee schedule
Class III	85% of CC	90% of of CC	Covered 85% of fee schedule
Orthodontics	85% of CC up to $3,500 per person per lifetime	85% of CC up to $3,500 per person per lifetime	Covered 50% of fee schedule up to $2,000 per person per lifetime

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Benefit	In-Network	Out-of-Network
Retiree Benefits		
(Up to age 65) Age 50 and over/Must Qualify Contribution Required Participant & Spouse Only	85% of CC after $100 annual patient deductible. 15% copay up to $1,000 per person per calendar year. $200,000 maximum benefit per person per calandar year.	75%* of MAB after $100 annual patient deductible. 25% copay up to $2,000 per person per calendar year. $200,000 maximum benefit per person per per calandar year.
Optical Benefits		
Optical Exam	Covered in full	Up to $50
Frames	Up to $125	Up to $75
Lenses (per pair)		
Single	Covered in full	Up to $50
Bi-focal	Covered in full	Up to $60
Tri-focal	Covered in full	Up to $70
Contact Lenses	Up to $120.00	Up to $70.
Progressive Lenses	Up to $85 plus 15% discount on balance	Up to $80
Polycarbonate (upto age 18)	Up to $20 plus 15% discount on balance	Not covered
Laser Vision Correction	Up to $250 per eye per lifetime	Not Covered

Benefit	Coverage
Death Benefit	
Participant	$20,000
Spouse	$3,000
Children (Birth up to age 19)	$1,500
Accidental Death & Dismemberment (Participant only)	$20,000 (Maximum)
Total & Permanent Disability Benefit (Participant only)	$250 per month $20,000 maximum benefit over an 80-month period
Weekly Accident & Sickness Benefit (Participant only)	$175 per week for a maximum of 26 weeks Payable on: 1st day for accident or 8th day for illness after the last day worked. Family coverage continues while member is collecting weekly benefit
Flex Dependent Coverage	For participants who are enrolled as a family, have other available coverage and elect to waive this dependent coverage, an annual medical spending account of up to $1,200 for family participants will be established for their use to offset expenses
Benefit Bank Weeks	You receive six weeks Benefit Bank for the three-year period beginning April 1, 2006 through March 31, 2009 to cover medical and prescription drug benefits.

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IMPORTANT TELEPHONE NUMBERS

The following telephone numbers are provided to assist you in determining your eligibility for benefits and maximizing your coverage under the Michigan Conference of Teamsters Welfare Fund. You may call the following numbers to ask questions about eligibility, benefits, locate an in-network provider, or to check the status of your claim.

Michigan Conference of Teamsters Welfare Fund Office..... (313) 964-2400
Toll free..... (800) 572-7687

Providers must call for prior authorization of:..... (313) 964-2400

Blepharoplsty & Potosis Repair; Upper Lid
Breast Reconstruction
Breast Reduction
Durable Medical Equipment - Purchase
Growth Hormone Stimulation
Hospice ext. 428
Home Health Care
PET Scan

No benefits will be paid if your provider does not call to obtain prior authorization

Call for prior authorization of:
Skilled nursing facility care..... (800) 482-4040

Provider must call to obtain prior authorization.

Call for prior authorization of treatment for:..... (800) 457-8540
Mental health and substance abuse conditions

Treatment of mental health and substance abuse conditions will not be covered if you do not obtain prior authorization before receiving treatment.

For prior authorization of Human Organ Transplant Procedures:
Have your physician or hospital call..... (800) 242-3504

Claims Anti-Fraud Hotlines
Medical and Optical Claims..... (800) 637-6907
Dental Claims..... (800) 524-0147
Blue Cross Blue Shield Claims..... (800) 482-3787

BlueHealthConnection 24-Hour Health Coach Hotline ..... (800) 775-Blue (2583)

Please note that BlueHealthConnection is not a 911 emergency line. In an emergency call 911.

To Locate a Participating Provider After Hours:
Blue Cross Blue Shield..... (800) 810-Blue (2583)
MultiPlan..... (800) 672-2140
Value Options..... (800) 457-8540
Delta Dental ..... (800) 524-0149
Delta Vision ..... (800) 524-0149