

SCHEDULE OF BENEFITS



Michigan Conference
of Teamsters Welfare Fund
Schedule of Benefits

Plan 384

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 Traditional 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	\$300 per individual \$600 per family	\$600 per Individual \$1,200 per family
Reimbursement	85% of CC	75% of MAB
Out-of-Pocket Maximum (In excess 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	Requires prior authorization		
Inpatient			
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 MAB up to 50 visits per year combined in/out mental health and substance abuse treatment	
Home Health Care	85%* of CC after deductible	85%* of MAB after deductible	
Requires prior authorization			
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	85%* of CC after deductible	85%* of MAB after deductible	
Requires prior authorization			
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	85%* of CC after deductible up to \$1,000 per person per aid	85%* after deductible up to \$1,000 per person per aid	
Covered every 2 years			
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

CC means Contracted Charges as described in your SPD

MAB means Maximum Allowable Benefit Charges as described in your SPD

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Benefit	In-Network	Out-of-Network
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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 calendar 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 calendar year.
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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
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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.

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

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

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