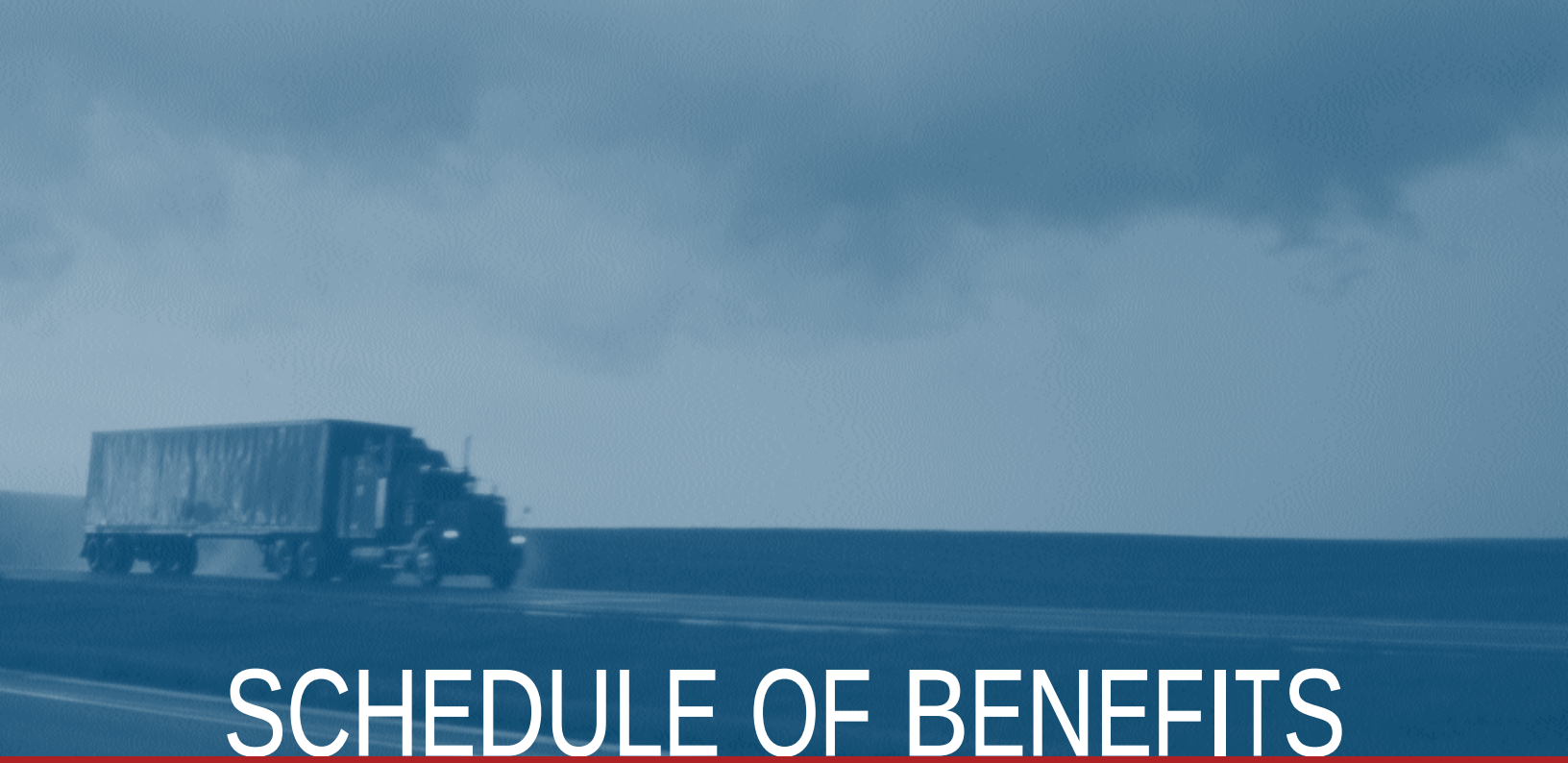

SCHEDULE OF BENEFITS

Michigan Conference
of Teamsters Welfare Fund
Schedule of Benefits

KEY III
2ENN3

July 2006

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 Blue Cross Blue Shield under their nationwide network. In-Network dental services are provided through Delta Dental of Michigan under the Delta Premier nationwide network of providers. When you receive services from a BCBS PPO, or Delta Dental of Michigan provider, you will experience little or no out-of-pocket expenses.

In-Network mental health and substance abuse services are provided by Value Options and 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, 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 and Delta Dental websites to obtain up-to-date listings of network health care providers, hospitals and dental providers

BENEFIT DETAILS

The following chart highlights the benefits provided as of July 1, 2006. 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	O
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 individual	$600 Individual
Reimbursement	80% of CC	60% of MAB
Out-of-Pocket Maximum (in excess of deductible)	$2,000 per individual $4,000 per family	$4,000 per individual $8,000 per family
Hospital Expenses	80%* of CC after deductible for up to 365 days semi-private	60%* of MAB after deductible for up to 365 days semi-private
Hospital Emergency Benefit	80%* of CC after deductible if it meets the criteria described in SPD	80% of MAB* after deductible if it meets the criteria described in SPD
Ambulance Ground/Air/Water	80% of CC after deductible	80% of MAB after deductible
Physician Charges Office	$20 co-pay	60%* of MAB after deductible
Hospital Outpatient Clinic Visit	80%* of CC after deductible	60%* of MAB after deductible
Inpatient	80%* of CC after deductible	60%* of MAB after deductible
Surgical Benefits	80%* of CC after deductible	60%* of MAB after deductible
Maternity Benefits Member/Spouse only Pre/Post-Natal Delivery	80%* of CC after deductible	60%* of MAB after deductible
Anesthesia	80%* of CC after deductible	60%* of MAB after deductible
X-ray	80%* of CC after deductible	60%* of MAB after deductible
Laboratory Tests: Fluids/Pathology/ Diagnostic Tests	80%* of CC after deductible	60%* of MAB after deductible
Wellness Mammography Screening	100% of CC deductible & copay waived	60%* of MAB after deductible
Wellness Physical Exam/GYN Exam	100% of CC deductible & copay waived	60%* of MAB after deductible
Wellness Pap Smear Screening	100% of CC deductible & copay waived	60%* of MAB after deductible
Well Child Exam	100% of CC deductible & copay waived	60%* of MAB after deductible
Wellness Child Immunizations	100% of CC deductible & copay waived	60%* 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
Mental Health & Substance Abuse Requires prior authorization Inpatient		
Hospital	45 days covered at 80%* of CC after deductible, per person per calendar year	45 days covered at 60%* of MAB after deductible, per person per calendar year
Physician	80% of CC up to 50 visits per year combining in/out mental health & substance abuse treatment.	60% 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	80%* of CC after deductible	80%* of MAB after deductible
Skilled Nursing Facility	80%* of CC after deductible for eligible expenses for room and board and other medical services	80%* of MAB after deductible for eligible expenses for room and board and other medical services
Hospice Care Requires prior authorization	80%* of CC after deductible	80%* of MAB after deductible
Chiropractic Benefits	80% of CC up to $1,000 per person per calendar year	60% of MAB up to $1,000 per person per calendar year
Hearing Aids Covered every 2 years	80%* of CC after deductible up to $1,000 per person per aid	80%* after deductible up to $1,000 per person per aid
Temporomandibular Joint Dysfunction (TMJ)	80%* of CC after deductible Up to $1,500 per person per lifetime	60%* of MAB after deductible Up to $1,500 per person per lifetime
Human Organ & Tissue Transplant Benefit	80%* of CC after deductible up to scheduled amount based upon organ type	60%* 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	
BCBS 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	
Dental Benefits Non-Orthodontic Services Annual Maximum	$1,500 per person	$1,500 per person
Deductible Class II & III	$50 Individual $100 Family	$50 Individual $100 Family
Class I	Covered in full	100% of fee schedule
Class II	100% of CC after deductible	100% of fee schedule after deductible
Class III	85% of CC after deductible	85% of fee schedule after deductible
Orthodontics	None	None

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	Coverage
Optical Benefits	
(Limited to one exam and one pair of corrective lenses every 12 months)	
Optical Exam	$50
Frames	$75
Lenses	
Single	$50 per pair
Bi-focal	$60 per pair
Tri-focal	$70 per pair
Contact Lenses	$80 per pair
Total & Permanent Disability Benefit (Member only)	$250 per month $20,000 maximum benefit over an 80-month period
Flex Dependent Coverage	For single participants or participants who are enrolled as a family, have other available coverage and elect to waive their dependent coverage, an annual medical spending account of up to $540 for single participants and $1,200 for family participants will be established for their use to offset out-of-pocket expenses, i.e. copays or deductibles
Benefit Bank Weeks	You receive six weeks Benefit Bank every three-year period beginning April 1, 2006 through March 31, 2009, and each period thereafter as approved by the Trustees

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

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