

SCHEDULE OF BENEFITS



Michigan Conference
of Teamsters Welfare Fund
Schedule of Benefits

KEY IV
January 2007



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 out-of-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 January 1, 2007. 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	\$600 individual	\$1,200 Individual
Reimbursement	80% of CC	60% of MAB
Out-of-Pocket Maximum (In excess of deductible)	\$5,000 per individual \$10,000 per family	\$10,000 per individual \$20,000 per family
Hospital Expenses	80%* of CC after deductible for up to 365 days semi-private \$250 copayment per admission	60%* of MAB after deductible for up to 365 days semi-private \$250 copayment per admission
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	\$25 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 \$250 copayment per admission	45 days covered at 60%* of MAB after deductible, per person per calendar year \$250 copayment per admission	
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 \$25 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			
Requires prior authorization			
Skilled Nursing Facility	80%* of CC after deductible	80%* of MAB after deductible	
Hospice Care	80%* of CC after deductible	80%* of MAB after deductible	
Requires prior authorization			
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	80%* of CC after deductible up to \$1,000 per person per aid	80%* after deductible up to \$1,000 per person per aid	
Covered every 2 years			
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 up to 34-day supply	100% of CC Generic: \$10 copay	Formulary Brand: \$20 copay	Non-Formulary Brand: \$40 copay
BCBS 90-day Retail up to 90-day supply	100% of CC Generic: \$20 copay	Formulary Brand: \$40 copay	Non-Formulary Brand: \$80 copay
Mail Order up to 90-day supply	100% of CC Generic: \$20 copay	Formulary Brand: \$40 copay	Non-Formulary Brand: \$80 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	In-Network	Out-of-Network
Death Benefit		
Member	\$10,000	
Spouse	\$1,500	
Children (Birth up to age 19)	\$750	
Accidental Death & Dismemberment (Member only)	\$10,000 (Maximum)	
Weekly Accident & Sickness Benefit (Member 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 their dependent coverage, an annual medical spending account of up to \$1,200 for family participants will be established for their use to offset out-of-pocket expenses, i.e. copays or deductibles	

