

SCHEDULE OF BENEFITS 501 B1

This chart shows what the Plan pays. All benefits are subject to the deductible except where noted otherwise.
See Rules and Regulations in this booklet for more information.

| Benefit Description | Explanation and Limitations | PPO Providers (In-Network) | Non-PPO Providers (Out of Network) |
|---|--|-------------------------------|---------------------------------------|
| Accident – Supplemental | <ul style="list-style-type: none"> • No deductible • 100% of 1st \$300.00 per accident if treated within 30 days of accident and charge is incurred within 6 months of the accident • After the 1st \$300.00 benefits payable @ 70% or 50% -subject to deductible | 70% | 50% |
| Acupuncture | <ul style="list-style-type: none"> • Payable when administered by a Physician (MD or DO) | 70% | 50% |
| Ambulance | <ul style="list-style-type: none"> • Air – Per Trip • Surface – Maximum of \$600.00 per trip | 70% | 50% |
| Anesthesia | | 70% | 50% |
| Assistant Surgeons | <ul style="list-style-type: none"> • Maximum of 20% of surgeon’s benefit | 70% | 50% |
| Blood transfusions and blood products | | 70% | 50% |
| Convalescent Care Facility • Not for custodial care | <ul style="list-style-type: none"> • Maximum allowable expense –\$80 per day. Not for custodial or long-term care; maximum of 60 days per Calendar Year. Must be preceded by hospitalization in a covered facility. • Max 60 days per calendar year | 80% | 80% |
| Chemotherapy | | 70% | 50% |
| Chiropractic Care • Manipulations and x-rays only | <ul style="list-style-type: none"> • Maximum allowance: \$40 per visit • Max 25 visits per year | 50% | 50% |
| COB -Carve Out Method | <ul style="list-style-type: none"> • Applies to Medical claims only | N/A | N/A |
| Death Benefits | <ul style="list-style-type: none"> • Employee \$5,000.00 • Dependent –when applicable- refer to Article 1 - \$1,000.00 | N/A | N/A |
| Deductible • Per calendar year | <ul style="list-style-type: none"> • \$300.00 per person • \$750.00 per family | N/A | N/A |
| Diagnostic Outpatient • X-ray and Laboratory | <ul style="list-style-type: none"> • No deductible • 100% of the 1st \$200.00 • After the 1st \$200 benefits payable @ 70% or 50% - subject to deductible. | 70% | 50% |

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|--|---|-------------------------------|---------------------------------------|
| Dietary/Nutritional/Herbal | <ul style="list-style-type: none"> • Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered. • No over-the-counter drugs are reimbursed. | N/A | N/A |
| Disability | <ul style="list-style-type: none"> • No Benefit | N/A | N/A |
| Durable Medical Equipment (DME) • Pre-determination only if over \$2000.00, out-of-network, or possibly not medically necessary | <ul style="list-style-type: none"> • Charges for rental of wheelchair, special Hospital Bed, iron lung, crutches, and other reasonable mechanical therapeutic and durable medical equipment, but not to exceed the purchase of such equipment. • Pre-determination done by medical management for CPAP machines, etc. | 70% | 50% |
| Hearing Benefit | <ul style="list-style-type: none"> • No Benefit Available | N/A | N/A |
| Home Health Care (Pre-determination) | <ul style="list-style-type: none"> • Maximum of 60 visits per year | 70% | 50% |
| Hospice Care (Pre-determination) | <ul style="list-style-type: none"> • Treatment for terminal illnesses for individuals whose life expectancy is six months or less | 70% | 50% |
| Hospital (Inpatient) (Pre-determination) | | 70% | 50% |
| Hospital – Other Charges | <ul style="list-style-type: none"> • Per calendar Year • Based on allowable expenses | 70% | 50% |
| Infertility (Pre-determination) | <ul style="list-style-type: none"> • Lifetime maximum \$10,000 for covered expenses | 70% | 50% |
| Laboratory Services | <ul style="list-style-type: none"> • Subject to deductible after 1st \$200 | 70% | 50% |
| Lifetime Max | <ul style="list-style-type: none"> • \$350,000.00 | N/A | N/A |
| Mammogram Benefit • No deductible (Effective 01/01/08) | <ul style="list-style-type: none"> • Women Ages 30 – 39: One single baseline mammogram during that ten year period, payable up to \$300.00. • Women age 40 & over: One mammogram every calendar year payable up to \$300.00. | 70% | 50% |
| Maternity Employee or legal spouse only once family coverage is in effect | <ul style="list-style-type: none"> • Maternity charges are paid @ global rate at time of delivery • Lab charges, ultrasound or non-fetal stress test not included in global charges | 70% | 50% |

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|--|--|-------------------------------------|---------------------------------------|
| Nutritional/ Dietary | <ul style="list-style-type: none"> • Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered. | N/A | N/A |
| Outpatient Expenses | | 70% | 50% |
| Outpatient Surgical Facility | <ul style="list-style-type: none"> • No pre-authorization required for in-network facilities. • Need to contact Medical Management for out-of-network facilities. • In a hospital-based or Free standing surgery center | 70% | 50% |
| Orthopedic Equipment Orthotics & Braces (Must have RX) | <ul style="list-style-type: none"> • Charges for prescribed orthopedic shoes and other supportive appliance • Includes replacement once every 12 months • Includes replacement once every 6 months for 19 years or under | 70% | 50% |
| Physician And Health Care Practitioner Office Services | <ul style="list-style-type: none"> • One co-pay per office visit • Charges for other services provided at the physician’s office paid at 70% or 50% | 100% less the \$20 co- pay | 50% Deductible Applies |
| Physical Exam • No deductible | <ul style="list-style-type: none"> • Paid at 100% up to \$250.00 maximum per calendar year • Includes routine evaluations, lab charges, x-rays • No co-pay | Up to max benefit of \$250.00 | Up to max benefit of \$250.00 |
| Physical, Occupational & Osteopathic Manipulative Therapy | <ul style="list-style-type: none"> • Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist • Prescription for frequency and duration required by a Physician (M.D. or D.O.) • 16 visits per calendar year combined • Does not include maintenance or Industrial care | 70% | 50% |
| Pre-Existing | <ul style="list-style-type: none"> • \$1,000.00 | 70% | 50% |

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|--|--|---|---|
| Prescription Drugs (Outpatient) | <ul style="list-style-type: none"> • Generic • Brand Name (no generic equivalent) • Brand Name (with generic equivalent) • Certain drugs will be covered by the plan only after less costly alternatives have been explored. In furtherance of such a program, the plan may be provide coverage of non prescription medications that would otherwise not be covered by the plan. | In-Network Retail Pharmacy <ul style="list-style-type: none"> • \$15 co-pay • \$35 co-pay • \$50 co-pay | Out of Network Pharmacy 50% |
| Preventative (Wellness) Service | Immunizations through age 18 and other treatment | 70% | 50% |
| Prosthetic Appliances | <ul style="list-style-type: none"> • Items replacing a missing body part, such as an artificial limb • Prescription of medical necessity required • Needs medical management pre-determination | 70% | 50% |
| Lasik (RK) | • NO BENEFIT | N/A | N/A |
| Radiology and Nuclear Medicine Services | | 70% | 50% |
| Smoking Cessation | • NO BENEFIT | N/A | N/A |

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|---|---|-------------------------------|---------------------------------------|
| Speech Therapy | <ul style="list-style-type: none"> • Payable when rendered by a Licensed Speech Pathologist • Covered for patients who have had an injury or surgery affecting speech for 90 days following the event. • Speech therapy benefits are available for dependent children under age 17 for diagnoses listed in the Plan Booklet. • Up to 32 visits per calendar year • Prescription for frequency and duration required by a physician • Needs medical management pre-determination | 70% | 50% |
| Stop Loss | <ul style="list-style-type: none"> • \$20,000.00 • Benefits payable @ 100% of allowable charges once stop loss has been met, unless otherwise noted. • Per calendar year | N/A | N/A |
| Surgeons | | 70% | 50% |
| TMJ (temporo-mandibular joint dysfunction) | <ul style="list-style-type: none"> • \$3,000.00 lifetime maximum benefit • Hospital In-patient facility charges not subject to the TMJ lifetime max. | 70% | 50% |
| Vision | No benefit | N/A | N/A |
| All Other Covered Charges | | 70% | 50% |

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS PLAN 501 B1

See Rules and Regulations in this booklet for more information.

HMC (800) 464-7101

| Benefits | Coinsurance Payable by the Plan | |
|-----------------------------|---|---|
| | Precertified Providers (In-Network) | Non-Precertified Providers (Out of Network) |
| Deductible | <ul style="list-style-type: none"> • No Deductible | <p align="center">\$250.00 per person \$750.00 per family</p> <ul style="list-style-type: none"> • Deductible applies in conjunction with individual and family medical deductible |
| Psychiatric | <ul style="list-style-type: none"> • 45 days per calendar year 120 per lifetime • Hospital – 100% of EMAP approved treatment • Professional Fees- 100% of EMAP approved treatment | <ul style="list-style-type: none"> • 45 days per calendar year 120 per lifetime • Hospital - 65% of EMAP negotiated rates • Professional Fees - 65% of EMAP approved treatment |
| Alcohol/ Drug | <ul style="list-style-type: none"> • 2 admits per lifetime • 28 day per admission • Detox – 2 per lifetime 7 days per admission • Treatment must be completed for benefits to be paid. • Hospital – 100% of EMAP approved treatment for first treatment 95% for second treatment • Professional Fees – 100% of EMAP approved treatment for first treatment 95% for second treatment | <ul style="list-style-type: none"> • 2 admits per lifetime • 28 day per admission • Detox – 2 per lifetime 7 days per admission • Treatment must be completed for benefits to be paid. • Hospital – 65% of EMAP negotiated rates • Professional fees – 65% of EMAP negotiated rates |
| Outpatient Treatment | <ul style="list-style-type: none"> • 50 visits per calendar year including MD's, Ph.D's and licensed social workers • No deductible • First 8 visits no co-pay applies • After 8 visits co-pay applies \$5 co-pay for Master level and Psychologist \$10 co-pay for MD's | <ul style="list-style-type: none"> • Deductible applies • 65% of EMAP negotiated rates |

SCHEDULE OF INDEMNITY DENTAL PLAN BENEFITS PLAN 501 B1

Note: Dental services may be obtained from any licensed dental care provider.

| | |
|---|---------------------------|
| Deductible | None |
| Annual Dental Plan Maximum | \$750.00 |
| Surgical Treatment <ul style="list-style-type: none"> • Excision of bony impacted teeth • Root canals with apicoectomy • Osseous surgery with graft or gingivectomy | 50% of Allowable expenses |
| Diagnostic & Preventative <ul style="list-style-type: none"> • Exams (2 per calendar year) • Fluoride Treatment (2 per calendar year) • Prophylaxis (2 per calendar year) • Bitewing X-Rays (2 per calendar year) • Full Mouth X-Rays (1 per calendar year) • Sealants • Space Maintainers | 80% of Allowable expenses |
| Restorative & Surgical Treatment <ul style="list-style-type: none"> • Fillings • Extractions • Oral Surgery • Anesthesia • Periodontal Services • Endodontics | 50% of Allowable expenses |
| Prosthetic Treatment <ul style="list-style-type: none"> • Crowns • Bridges • Dentures (Replacements limited to every 5 years) | 50% of Allowable expenses |
| Orthodontic | No Benefits |
| Waiting Period | 18 month waiting period |

SSA MEXICO PPO NETWORK

Optional Benefit Program For Medical and Dental Expenses

The following benefits are covered at 100% of Allowed Amount, After your co-pay

If discharge planning is needed in the USA after a procedure, contact Medical Management department for care coordination

| | |
|---|--|
| \$5.00 co-pay | <ul style="list-style-type: none">• Medical /Hospital Expenses |
| \$5.00 co-pay | <ul style="list-style-type: none">• Dental – Waiting Period 18 months |
| \$3.00 co-pay | <ul style="list-style-type: none">• For each prescription• Medications that do not require an RX in the United States, will not be covered |
| Benefits will be paid to the appropriate provider through the SSA network <u>ONLY THE SERVICES WHICH ARE RENDERED BY THESE PROVIDERS WILL BE COVERED.</u> | |
| Contact the Fund Office with questions regarding your benefits | |