

SCHEDULE OF BENEFITS 501 D

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 @ 80% or 60% subject to deductible 	80%	60%
Acupuncture	<ul style="list-style-type: none"> • Payable when administered by a Physician (MD or DO) 	80%	60%
Ambulance	<ul style="list-style-type: none"> • Air – Per Trip • Surface – Maximum of \$600.00 per trip 	80%	60%
Anesthesia		80%	60%
Assistant Surgeons	<ul style="list-style-type: none"> • Maximum of 20% of surgeon’s benefit 	80%	60%
Blood transfusions and blood products		80%	60%
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 • Not to exceed 50% of average semi-private rate of hospital from which transferred 	80%	80%
Chemotherapy		80%	60%
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 \$1,000.00 	N/A	N/A
Deductible • Per calendar year	<ul style="list-style-type: none"> • \$250.00 per person • \$750.00 per family 	N/A	N/A
Diagnostic Outpatient • X-ray and Laboratory	<ul style="list-style-type: none"> • 100% of the 1st \$200.00 • After the 1st \$200.00 benefits payable @ 80% or 60% - subject to deductible. 	80%	60%
Dialysis		80%	60%

SCHEDULE OF BENEFITS 501 D

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)
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
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. 	80%	60%
Emergency Room (ER)		80%	60%
Hearing Benefit	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Home Health Care (Pre-determination)	<ul style="list-style-type: none"> Maximum of 60 visits per year 	80%	60%
Hospice Care (Pre-determination)	<ul style="list-style-type: none"> Treatment for terminal illnesses for individuals whose life expectancy is six months or less 	80%	60%
Hospital (Inpatient) (Pre-determination)	<ul style="list-style-type: none"> Room and Board Intensive Care Unit 	80%	60%
Hospital – Other Charges	<ul style="list-style-type: none"> Per calendar Year Based on allowable expenses 	80%	60%
Infertility (Pre-determination)	<ul style="list-style-type: none"> Lifetime maximum \$10,000 for covered expenses 	80%	60%
Laboratory Services	<ul style="list-style-type: none"> Subject to deductible after 1st \$200 	80%	60%
Lifetime Max	<ul style="list-style-type: none"> \$250,000.00 	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. 	80%	60%
Maternity For employee or legal spouse only	<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 	80%	60%
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

SCHEDULE OF BENEFITS 501 D

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)
Outpatient Expenses		80%	60%
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 	80%	60%
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 	80%	60%
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 80% or 60% 	100% less the \$20 co-pay	60% Deductible Applies
Physical Exam • No Deductible	<ul style="list-style-type: none"> • Paid at 100% up to \$200 maximum per calendar year • Includes routine evaluations, lab charges, x-rays • No co-pay 	Up to max benefit of \$200.00	Up to max benefit of \$200.00
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 	80%	60%
Pre-Existing	• \$1,000.00	80%	60%

SCHEDULE OF BENEFITS 501 D

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)
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 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"> • \$6 co-pay • \$15 co-pay • \$20 co-pay 	Out of Network Pharmacy 60%
Preventive (Wellness) Services	<ul style="list-style-type: none"> • Immunization through age 18 and other treatment 	80%	60%
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 	80%	60%
Lasik (RK)	<ul style="list-style-type: none"> • No Benefit 	N/A	N/A
Radiology and Nuclear Medicine Services		80%	60%
Smoking Cessation	<ul style="list-style-type: none"> • No Benefit 	N/A	N/A
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 	80%	60%

SCHEDULE OF BENEFITS 501 D

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)
Surgeons		80%	60%
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. 	80%	60%
Well Baby Care (Co-Pay applies to Office Visit)	<ul style="list-style-type: none"> • Immunization through age 18 and other treatment 	80%	60%
Working Spouse Reduction	<ul style="list-style-type: none"> • Benefit rate payable for spouse's charges when other insurance is offered through their employer but is declined 	40%	40%
All Other Covered Charges		80%	60%

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS 501 D

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 style="text-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 DENTAL PLAN BENEFITS 501 D

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

Deductible	\$50.00 •No Deductible for Medicos Mexico Services
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 Benefit

SCHEDULE OF VISION PLAN BENEFITS 501 D

Payable vision services must be obtained from the in-network Vision Care Providers. Contact the Vision Plan (as noted on the Quick Reference Chart) for the list of in-network vision providers.

Vision Services Call VSP 1-800-877-7195 In- Network	Non- Network	
Vision Exam <ul style="list-style-type: none"> • Covered in Full • Once within two consecutive calendar years 	\$35.00	Benefit allowances same as In-network. Bills must be submitted to VSP for reimbursement. Services rendered in Mexico paid by SSA
Lenses: <ul style="list-style-type: none"> • Covered in full • Single vision, lined bifocal and lined trifocal lenses 	Single \$42 Bi-Focal \$65 Tri-Focal \$82 Lenticular \$82	
Contact Lenses <ul style="list-style-type: none"> • If Medically Necessary • Once within two consecutive calendar years • Your \$117.00 allowance applies to cost and the fitting and evaluation exam. 	\$190	
Contact Lenses <ul style="list-style-type: none"> • Cosmetic 	\$82	
Frame Allowance <ul style="list-style-type: none"> • Once within two consecutive calendar years • Covered up to \$115.00 Plus 20% off any out of pocket cost. 	\$40	

SCHEDULE OF DISABILITY INCOME BENEFITS 501 D
See Rules and Regulations in this booklet for more information (Article 6)

Accident	No Benefit
Illness	No Benefit
Maximum Benefit period	No Benefit
Benefit Percentage	No Benefit

SSA MEXICO PPO NETWORK

Optional Benefit Program For Medical, Dental and Vision 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 / Vision Expenses
\$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	