

## SCHEDULE OF BENEFITS RETIREES

This chart shows what the Plan pays. All benefits are subject to the deductible except where noted otherwise.  
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Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
<b>Accident – Supplemental</b>	<ul style="list-style-type: none"> <li>• No Benefit</li> <li>• Allowed charges paid under major medical</li> </ul>	N/A	N/A
<b>Acupuncture</b>	<ul style="list-style-type: none"> <li>• Payable when administered by a Physician (MD or DO)</li> </ul>	90%	80%
<b>Ambulance</b>	<ul style="list-style-type: none"> <li>• Air – Per Trip</li> <li>• Surface – Maximum of \$600.00 per trip</li> </ul>	90%	80%
<b>Anesthesia</b>		90%	80%
<b>Annual Automatic Restoration</b>	<ul style="list-style-type: none"> <li>• \$2,000.00</li> </ul>	N/A	N/A
<b>Assistant Surgeons</b>	<ul style="list-style-type: none"> <li>• Maximum of 20% of surgeon’s benefit</li> </ul>	90%	80%
<b>Blood transfusions and blood products</b>		90%	80%
<b>Convalescent Care Facility</b>	<ul style="list-style-type: none"> <li>• Maximum allowable expense –of \$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.</li> <li>• Must be preceded by hospitalization of at least 31 days duration</li> <li>• Max 60 days per calendar year</li> </ul>	80%	80%
<b>Chemotherapy</b>		90%	80%
<b>Chiropractic Care</b>	<ul style="list-style-type: none"> <li>• Maximum allowance: \$40 per visit</li> <li>• Max 13 visits per year</li> </ul>	50%	50%
<ul style="list-style-type: none"> <li>• Manipulations and x-rays only</li> </ul>			
<b>Death Benefits</b>	<ul style="list-style-type: none"> <li>• No Benefits</li> </ul>	N/A	N/A
<b>Deductible</b>	<ul style="list-style-type: none"> <li>• \$200.00 per person</li> <li>• Applied in conjunction with Mental Health/Substance Abuse Deductible</li> </ul>	N/A	N/A
<ul style="list-style-type: none"> <li>• Per calendar year</li> </ul>			
<b>Dental</b>	<ul style="list-style-type: none"> <li>• No Benefits</li> </ul>	N/A	N/A
<b>Diagnostic Outpatient</b>	<ul style="list-style-type: none"> <li>• 100% of the 1<sup>st</sup> \$200.00</li> <li>• After the 1<sup>st</sup> \$200.00 benefits payable @ 90% or 80% - subject to deductible.</li> </ul>	90%	80%
<ul style="list-style-type: none"> <li>• X-ray and Laboratory</li> </ul>			
<b>Dialysis</b>		90%	80%
<b>Dietary/Nutritional/Herbal</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• No over-the-counter drugs are reimbursed</li> </ul>	N/A	N/A

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<b>Disability</b>	<ul style="list-style-type: none"> <li>No Benefit</li> </ul>	N/A	N/A
<b>Durable Medical Equipment (DME)</b> <ul style="list-style-type: none"> <li>Pre-determination only if over \$2000.00, out-of-network, or possibly not medically necessary</li> </ul>	<ul style="list-style-type: none"> <li>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</li> <li>Charges made for oxygen, its administration and the rental of oxygen equipment, not to exceed the purchase price of such equipment</li> <li>Pre-determination done by medical management for CPAP machines, etc.</li> </ul>	90%	80%
<b>Emergency Room (ER)</b>		90%	80%
<b>Hearing Benefit</b> <ul style="list-style-type: none"> <li>Allowable charges only</li> </ul>	<ul style="list-style-type: none"> <li>Per Calendar Year Maximums:                             <ul style="list-style-type: none"> <li>\$100 for examination</li> <li>\$75 for repair (excludes batteries)</li> </ul> </li> <li>\$850 for pair of hearing appliances (every three years)</li> </ul>	90%	80%
<b>Home Health Care (Pre-determination)</b>	<ul style="list-style-type: none"> <li>Maximum of 60 visits per year</li> </ul>	90%	80%
<b>Hospice Care (Pre-determination)</b>	<ul style="list-style-type: none"> <li>Treatment for terminal illnesses for individuals whose life expectancy is six months or less</li> </ul>	90%	80%
<b>Hospital (Inpatient) (Pre-determination)</b>	<ul style="list-style-type: none"> <li>Room and Board – Maximum per day \$280.00</li> <li>Once stop loss of \$10,000.00 has been met is payable @ 100%</li> </ul>	90%	80%
<b>Hospital Intensive Care Unit</b>	<ul style="list-style-type: none"> <li>Room and Board – Maximum per day \$700.00</li> </ul>	90%	80%
<b>Hospital – Other Charges</b>		90%	80%
<b>Infertility (Pre-determination)</b>	<ul style="list-style-type: none"> <li>No Benefit</li> </ul>	N/A	N/A
<b>Mammogram Benefit</b> <ul style="list-style-type: none"> <li>No deductible</li> </ul> <b>(Effective 01/01/08)</b>	<ul style="list-style-type: none"> <li>Women Ages 30 – 39: One single baseline mammogram during that ten year period, payable up to \$300.00.</li> <li>Women age 40 &amp; over: One mammogram every calendar year payable up to \$300.00.</li> </ul>	90%	80%
<b>Maternity</b>	<ul style="list-style-type: none"> <li>Maternity charges are paid @ global rate at time of delivery</li> <li>Lab charges, ultrasound or non-fetal stress test not included in global charges</li> </ul>	90%	80%
<b>Maximum Lifetime Benefit</b>	<ul style="list-style-type: none"> <li>\$100,000.00</li> <li>Applied in conjunction with Mental Health/Substance Abuse lifetime maximum</li> </ul>	N/A	N/A
<b>Outpatient Expenses</b>		90%	80%

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<b>Outpatient Surgical Facility</b>	<ul style="list-style-type: none"> <li>• No pre-authorization required for in-network facilities</li> <li>• Need to contact Medical Management for out-of-network facilities.</li> <li>• No Deductible</li> <li>• In a hospital-based or Free standing surgery center</li> </ul>	100%	100%
<b>Orthopedic Equipment Orthotics &amp; Braces (Must have RX)</b>	<ul style="list-style-type: none"> <li>• Charges for prescribed orthopedic shoes and other supportive appliance</li> <li>• Includes replacement once every 12 months</li> </ul>	90%	80%
<b>Physician And Health Care Practitioner Office Services</b>	<ul style="list-style-type: none"> <li>• One co-pay per office visit</li> <li>• Maximum of 26 visits per year</li> <li>• Charges for other services provided at the physician's office paid at 90% or 80%</li> </ul>	100% less the \$15 co-pay	80% Deductible Applies
<b>Physical Exam</b> • No deductible	<ul style="list-style-type: none"> <li>• Paid at 100% up to \$100.00 maximum per calendar year</li> <li>• Includes routine evaluations, lab charges, x-rays</li> <li>• No co-pay</li> </ul>	Up to max benefit of \$100.00	Up to max benefit of \$100.00
<b>Physical, Occupational &amp; Osteopathic Manipulative Therapy</b>	<ul style="list-style-type: none"> <li>• Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist</li> <li>• Pre-determination is required</li> <li>• Prescription for frequency and duration required by a Physician (M.D. or D.O.)</li> <li>• 16 visits per calendar year combined</li> <li>• Does not include maintenance or Industrial care</li> </ul>	90%	80%
<b>Pre-Existing</b>	• None	N/A	N/A

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<b>Prescription Drugs (Outpatient)</b>	<ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand Name (no generic equivalent)</li> <li>• Brand Name (with generic equivalent)</li> <li>• 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.</li> </ul>	<b>In-Network Retail Pharmacy</b> <ul style="list-style-type: none"> <li>• \$10 co-pay</li> <li>• \$35 co-pay</li> <li>• \$50 co-pay</li> </ul>	<b>Out of Network Pharmacy</b>  80%
<b>Prosthetic Appliances</b>	<ul style="list-style-type: none"> <li>• Items replacing a missing body part, such as an artificial limb</li> <li>• Prescription of medical necessity required</li> <li>• Needs medical management pre-determination</li> </ul>	90%	80%
<b>Radiology and Nuclear Medicine Services</b>		90%	80%
<b>Smoking Cessation</b>	<ul style="list-style-type: none"> <li>• No Deductible</li> <li>• Lifetime Benefit</li> <li>• 100% up to \$250 maximum</li> </ul>	Up to max benefit	Up to max benefit
<b>Speech Therapy</b>	<ul style="list-style-type: none"> <li>• Payable when rendered by a Licensed Speech Pathologist</li> <li>• Covered for patients who have had an injury or surgery affecting speech for 90 days following the event.</li> <li>• Speech therapy benefits are available for dependent children under age 17 for diagnoses listed in the Plan Booklet.</li> <li>• Up to 32 visits per calendar year</li> <li>• Prescription for frequency and duration required by a Physician</li> <li>• Needs medical management pre-determination</li> </ul>	90%	80%

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<b>Stop Loss</b>	<ul style="list-style-type: none"> <li>• \$20,000.00</li> <li>• Benefits payable @ 100% of allowable charges once stop loss has been met, unless otherwise noted.</li> <li>• Per calendar year</li> </ul>	N/A	N/A
<b>Surgeons</b>		90%	80%
<b>Surgical Facility</b>	<ul style="list-style-type: none"> <li>• Free standing or Outpatient</li> </ul>	100%	100%
<b>TMJ (temporo-mandibular joint dysfunction)</b>	<ul style="list-style-type: none"> <li>• \$3,000.00 lifetime maximum benefit ( effective 3/1/06) Prior to 3/1/06 was \$2,000.00</li> <li>• Hospital In-patient facility charges not subject to the TMJ lifetime max.</li> </ul>	90%	80%
<b>Vision</b>	<ul style="list-style-type: none"> <li>• No Benefit</li> </ul>	N/A	N/A
<b>All Other Covered Charges</b>		90%	80%

## SCHEDULE OF BEHAVIORAL HEALTH BENEFITS RETIREES

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)
<b>Deductible</b>	<ul style="list-style-type: none"> <li>• No Deductible</li> </ul>	<p style="text-align: center;">\$200.00 per person</p> <ul style="list-style-type: none"> <li>• Deductible applies in conjunction with individual and family medical deductible</li> </ul>
<b>Psychiatric</b>	<ul style="list-style-type: none"> <li>• 45 days per calendar year 120 per lifetime</li> <li>• Hospital – 100% of EMAP approved treatment</li> <li>• Professional Fees- 100% of EMAP approved treatment</li> </ul>	<ul style="list-style-type: none"> <li>• 45 days per calendar year 120 per lifetime</li> <li>• Hospital - 65% of EMAP negotiated rates</li> <li>• Professional Fees - 65% of EMAP approved treatment</li> </ul>
<b>Alcohol/ Drug</b>	<ul style="list-style-type: none"> <li>• 2 admits per lifetime</li> <li>• 28 day per admission</li> <li>• Detox – 2 per lifetime 7 days per admission</li> <li>• Treatment must be completed for benefits to be paid.</li> <li>• Hospital – 100% of EMAP approved treatment for first treatment 95% for second treatment</li> <li>• Professional Fees – 100% of EMAP approved treatment for first treatment 95% for second treatment</li> </ul>	<ul style="list-style-type: none"> <li>• 2 admits per lifetime</li> <li>• 28 day per admission</li> <li>• Detox – 2 per lifetime 7 days per admission</li> <li>• Treatment must be completed for benefits to be paid.</li> <li>• Hospital – 65% of EMAP negotiated rates</li> <li>• Professional fees – 65% of EMAP negotiated rates</li> </ul>
<b>Outpatient Treatment</b>	<ul style="list-style-type: none"> <li>• 50 visits per calendar year including MD's, Ph.D's and licensed social workers</li> <li>• No deductible</li> <li>• First 8 visits no co-pay applies</li> <li>• After 8 visits co-pay applies: \$5 co-pay for Master level and Psychologist \$10 co-pay for MD's</li> </ul>	<ul style="list-style-type: none"> <li>• Deductible applies</li> <li>• 65% of EMAP negotiated rates</li> </ul>

**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

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