

## SCHEDULE OF BENEFITS RETIREES

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<br>(In-Network) | Non-PPO Providers<br>(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</li> </ul> Subject to deductible   | 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> Subject to deductible   | 90%                           | 80%                                   |
| <b>Anesthesia</b>  | Subject to deductible  | 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> Subject to deductible  | 90%                           | 80%                                   |
| <b>Blood transfusions and blood products</b>   | Subject to deductible  | 90%                           | 80%                                   |
| <b>Convalescent Care Facility</b> <ul style="list-style-type: none"> <li>Not for custodial care</li> </ul> <b>Pre-Certification Required</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 of at least 31 days duration</li> </ul> Subject to deductible                                | 80%                           | 80%                                   |
| <b>Chemotherapy</b>  | Subject to deductible  | 90%                           | 80%                                   |
| <b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>Manipulations and x-rays only</li> </ul>                                     | <ul style="list-style-type: none"> <li>Maximum allowance: \$40 per visit</li> <li>Max 13 visits per year</li> </ul> Subject to deductible  | 50%                           | 50%                                   |
| <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>Per calendar year</li> </ul>  | <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                                   |
| <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>X-ray and Laboratory</li> </ul>  | <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%                                   |
| <b>Diabetic Supplies</b><br>(Effective 1/1/2010)   | <ul style="list-style-type: none"> <li>Diabetic Supply Program through Nations Health–mail order, No co-pay, no deductible; paid at 100% - call 1-800-354-1653</li> </ul>  | 90%                           | 80%                                   |
| <b>Dialysis</b>  | Subject to deductible  | 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>• 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> </ul> <p style="margin-left: 20px;">Subject to deductible</p> | 90%                           | 80%                                   |
| <b>Emergency Room (ER)</b>  | Subject to deductible  | 90%                           | 80%                                   |
| <b>Experimental Treatment</b>                                       | Vax-D, IDD and any other experimental treatment is not covered.  | 0%                            | 0%                                    |
| <b>Hearing Benefit</b><br>• Allowable charges only                  | <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)                             <ul style="list-style-type: none"> <li>• Subject to deductible</li> </ul> </li> </ul>  | 90%                           | 80%                                   |
| <b>Home Health Care</b>   | <ul style="list-style-type: none"> <li>• Maximum of 60 visits per year</li> </ul> <p style="margin-left: 20px;">Subject to deductible</p>  | 90%                           | 80%                                   |
| <b>Hospice Care</b>   | <ul style="list-style-type: none"> <li>• Treatment for terminal illnesses for individuals whose life expectancy is six months or less</li> </ul> <p style="margin-left: 20px;">Subject to deductible</p>   | 90%                           | 80%                                   |
| <b>Hospital (Inpatient) (Pre-Certification)</b>                     | <ul style="list-style-type: none"> <li>• Room and Board – Maximum per day \$280.00 for Non-PPO</li> </ul> <p style="margin-left: 20px;">Subject to deductible</p>  | 90%                           | 80%                                   |
| <b>Hospital Intensive Care Unit</b>                                 | <ul style="list-style-type: none"> <li>• Room and Board – Maximum per day \$700.00 for Non-PPO</li> </ul> <p style="margin-left: 20px;">Subject to deductible</p>  | 90%                           | 80%                                   |
| <b>Hospital – Other Charges</b>                                     | Subject to deductible  | 90%                           | 80%                                   |
| <b>Infertility</b>  | • No Benefit   | N/A                           | N/A                                   |
| <b>Laboratory Services</b>  | • Subject to deductible after 1 <sup>st</sup> \$200  | 90%                           | 80%                                   |
| <b>Lifetime Max</b>   | • \$100,000.00   | N/A                           | N/A                                   |
| <b>Mammogram Benefit</b><br>• No deductible<br>(Effective 01/01/08) | <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> <li>• Healthy Maternity Program: Initial OB Care – Call the Fund Office to enroll</li> </ul>   | 90%                           | 80%                                   |

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|--|---|--|---|
| <b>Nutritional/ Dietary</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> </ul>  | N/A  | N/A   |
| <b>Orthopedic Equipment<br/>Orthotics &amp; Braces<br/>(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> Subject to deductible   | 90%  | 80%   |
| <b>Outpatient Expenses</b>   | Subject to deductible   | 90%  | 80%   |
| <b>Outpatient Surgical Facility</b>  | <ul style="list-style-type: none"> <li>No pre-authorization required for in-network facilities</li> <li>No Deductible</li> <li>In a hospital-based or Free standing surgery center</li> </ul>   | 100%   | 100%  |
| <b>Physician And Health Care<br/>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<br>the \$15 co-<br>pay   | 80%<br>Deductible<br>Applies                      |
| <b>Physical Exam</b><br>• No deductible                                      | <ul style="list-style-type: none"> <li>Paid at 100% up to \$100.00 max per calendar year</li> <li>Includes routine evaluations, lab charges, x-rays</li> <li>No co-pay</li> </ul>   | Up to max<br>benefit of<br>\$100.00  | Up to max<br>benefit of<br>\$100.00               |
| <b>Physical, Occupational &amp;<br/>Osteopathic Manipulative<br/>Therapy</b> | <ul style="list-style-type: none"> <li>Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist</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> Subject to deductible  | 90%  | 80%   |
| <b>Pre-Certification/Authorization</b>                                       | Also required for SNF admits & Transplants – Call Medical Management, (602) 249-3582 option 6   |  |   |
| <b>Pre-Existing</b>  | • None  | N/A  | N/A   |
| <b>Prescription Drugs<br/>(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<br/>Retail<br/>Pharmacy</b><br><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<br/>Network<br/>Pharmacy</b><br><br>80% |

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|---|---|-------------------------------|---------------------------------------|
| <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> </ul> Subject to deductible   | 90%                           | 80%                                   |
| <b>Lasik (RK)</b>                                 | <ul style="list-style-type: none"> <li>• No Benefit</li> </ul>  | N/A                           | N/A                                   |
| <b>Radiology and Nuclear Medicine Services</b>    | Subject to deductible   | 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. <b>(Pre-certification required).</b></li> <li>• Up to 32 visits per calendar year</li> <li>• Prescription for frequency and duration required by a Physician</li> <li>• Subject to deductible</li> </ul> | 90%                           | 80%                                   |
| <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>                                   | Subject to deductible   | 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</li> <li>• Hospital In-patient facility charges not subject to the TMJ lifetime max.</li> </ul> Subject to deductible  | 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>                  | Subject to deductible   | 90%                           | 80%                                   |

### In Network



### Secondary Wrap Network



## 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<br>(In-Network)  | Non-Precertified Providers<br>(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:<br/>\$5 co-pay for Master level and Psychologist<br/>\$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<br><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  |  |