

Plan A Schedule of Benefits

Plan A Schedule of Benefits – Effective January 1, 2012. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the “Out-of-Area” column apply only when the Eligible Individual resides more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Health Plan Benefits — Plan A			
Calendar Year Maximum	\$2,000,000 per person, per calendar year (starting January 1, 2014 there will be no annual overall dollar maximum)		
Deductible	None		
Coinsurance	Plan pays the amount shown below; subject to coinsurance limit		
Annual Coinsurance Limit	\$15,000 per person; \$30,000 family maximum – (of Allowed Charges)		
Benefit Description	Contract Provider	Non-Contract Provider+	Out-of-Area+
Inpatient Hospital (pre-authorization required)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 90%; subject to coinsurance limit	Plan pays 90%; subject to coinsurance limit	Plan pays 90%; subject to coinsurance limit
Ambulatory Surgery Facility or Outpatient Hospital for Surgery	Plan pays 90%; subject to coinsurance limit	Plan pays 80%	Plan pays 90%; subject to coinsurance limit
Other Outpatient Hospital	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Physician Visits (Office, Hospital, and Home)	After \$10 Copayment per visit, Plan pays 100%	After \$10 Copayment per visit, Plan pays 60%	After \$10 Copayment per visit, Plan pays 90%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Speech Therapy ¹ Calendar Year Maximum: \$1,000 Lifetime Maximum: \$2,000	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Occupational Therapy	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Preventive Care for Children	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 60%	Plan pays 90%; subject to coinsurance limit

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan A	Contract Provider	Non-Contract Provider+	Out-of-Area+
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 100% for a routine physical exam, up to \$150 per exam	Plan pays 100% for a routine physical exam, up to \$150 per exam
Preventive Care for Women including Pregnant Women	Plan pays 100% for services required to be covered under Health Care Reform (including screening mammograms)	Plan pays 100% for a routine physical exam, up to \$150 per exam. Mammograms: Plan pays 60%	Plan pays 100% for a routine physical exam, up to \$150 per exam Mammograms: Plan pays 90%;subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After \$10 Copayment per visit, Plan pays 100%	After \$10 Copayment per visit, Plan pays 60%	After \$10 Copayment per visit, Plan pays 90%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	Plan pays 90%; subject to coinsurance limit	Plan pays 90%	Plan pays 90%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	Plan pays 90%; subject to coinsurance limit	Plan pays 90%	Plan pays 90%; subject to coinsurance limit
Ambulance	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: \$1,500	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	Plan pays 90%; subject to coinsurance limit	Plan pays 60%	Plan pays 90%, subject to coinsurance limit

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan A	Contract Provider	Non-Contract Provider+	Out-of-Area+
Outpatient Mental Illness for covered providers only	Professional charges: After \$10 Copayment per visit, Plan pays 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After \$10 Copayment per visit, Plan pays 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After \$10 Copayment per visit, Plan pays 90% Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
¹ Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.			

Prescription Drug Benefits	
Participating Retail Pharmacy	Your Copayment for each prescription: Generic Drug: \$10 Brand Name Drug: \$15 Maximum Supply: 34 days
Mail Order Program:	Your Copayment for each prescription: Generic Drug: \$5 Brand Name if a Generic is available: \$25 Brand Name if No Generic available: \$10 Maximum Supply: 90 days
<p>If the actual cost of the prescription is less than the Copayment, you pay the actual cost.</p> <p>If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent, the remaining amount will be your responsibility, in addition to your Copayment.</p>	

Hearing Aid Benefit	
Hearing Examination	Plan pays 80% of Allowed Charge
Hearing Aid	Plan pays 80% of Allowed Charges (limited to one device per ear in any 3-year period)
Maximum Benefit	\$450 per ear

Chemical Dependency Treatment Benefits	
Inpatient Residential Treatment Pre-authorization by Assistance Recovery Program (ARP) required	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers.
Outpatient Treatment Referral and pre-authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers. Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Dental Benefits ⁽¹⁾	Coverage
Deductible	None
Diagnostic and Preventive Benefits	Plan pays 100% of allowed charge
Basic Benefits	Plan pays 85% of allowed charge
Restoration Benefits	Plan pays 85% of allowed charge
Prosthetic Benefits	Plan pays 60% of allowed charge
Calendar Year Maximum (does not apply to dependent children up to age 18)	\$2,500 per person
¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.	

Vision Benefits ⁽¹⁾⁽²⁾	VSP Providers	Non-VSP Providers
Copayment	\$7.50	\$7.50
Vision Examination – Limited to once every 12 months	Plan pays 100%	Plan pays up to \$45 per exam
Lenses – Limited to once every 12 months Single Vision Bifocal Trifocal Lenticular	Plan pays 100% up to network provider scheduled allowances	Plan pays up to: \$34 \$51 \$68 \$100
Frames – Limited to once every 24 months	Up to \$140 retail frame allowance	\$70
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in full	Plan pays up to \$210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to \$100 for exam and lenses	Plan pays up to \$100 for exam and lenses
Primary EyeCare Benefit (visits for the detection and treatment of medical conditions of the eye that are not just vision problems)	\$20 copay per office visit	Not covered
⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.		
⁽²⁾ Limitations on frequency of services do not apply to VSP Provider services for children under age 18.		

Plan B Schedule of Benefits

Schedule of Benefits – Effective January 1, 2012. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the “Out-of-Area” column apply only when the Eligible Individual lives more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Medical Benefits — Plan B			
Calendar Year Maximum	\$2,000,000 per person, per calendar year (starting January 1, 2014 there will be no annual overall dollar maximum)		
Deductible	None		
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit		
Annual Coinsurance Limit	\$15,000 per person; \$30,000 family maximum – (of Allowed Charges)		
Benefit Description	Contract Provider	Non-Contract Provider⁺	Out-of-Area⁺
Inpatient Hospital (pre-authorization required)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 80%; subject to coinsurance limit	Plan pays 80%; subject to coinsurance limit	Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility / Outpatient Hospital for Surgery	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Other Outpatient Hospital	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Physician Visits (Office, Hospital, and Home)	After \$15 Copayment per visit, Plan pays 100%	After \$15 Copayment per visit, Plan pays 60%	After \$15 Copayment per visit, Plan pays 80%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Speech Therapy ¹ Calendar Year Maximum: \$1,000 Lifetime Maximum: \$2,000	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Occupational Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Preventive Care for Children	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 60%	Plan pays 80%; subject to coinsurance limit

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan B	Contract Provider	Non-Contract Provider+	Out-of-Area+
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform	Plan pays 100% for a routine physical exam, up to \$150 per exam	Plan pays 100% for a routine physical exam, up to \$150 per exam
Preventive Care for Women including Pregnant Women	Plan pays 100% for services required to be covered under Health Care Reform (including screening mammograms)	Plan pays 100% for a routine physical exam, up to \$150 per exam' Mammograms: Plan pays 60%	Plan pays 100% for a routine physical exam, up to \$150 per exam Mammograms: Plan pays 80%;subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After \$15 Copayment per visit, Plan pays 100%	After \$15 Copayment per visit, Plan pays 60%	After \$15 Copayment per visit, Plan pays 80%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Ambulance	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: \$1,500	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	Plan pays 80%; subject to coinsurance limit	Plan pays 60%	Plan pays 80%; subject to coinsurance limit

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan B	Contract Provider	Non-Contract Provider+	Out-of-Area+
Outpatient Mental Illness for covered providers only	Professional charges: After \$15 Copayment per visit, Plan pays 100% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After \$15 Copayment per visit, Plan pays 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After \$15 Copayment per visit, Plan pays 80% Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	Plan pays 80%; subject to coinsurance limit	Plan pays 80%	Plan pays 80%; subject to coinsurance limit
<p>¹ Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.</p>			

Prescription Drug Benefits

Participating Retail Pharmacy	Your Copayment for each prescription: Generic Drug: \$10 Brand Name Drug: \$15 Maximum Supply: 34 days
Mail Order Program:	Your Copayment for each prescription: Generic Drug: \$5 Brand Name if a Generic is available: \$25 Brand Name if No Generic available: \$10 Maximum Supply: 90 days
<p>If the actual cost of the prescription is less than the Copayment, you pay the actual cost. If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent, the remaining amount will be your responsibility, in addition to your Copayment.</p>	

Hearing Aid Benefit

Hearing Examination	Plan pays 80% of Allowed Charge
Hearing Aid	Plan pays 80% of Allowed Charges (limited to one device per ear in any 3-year period)
Maximum Benefit	\$450 per ear

Chemical Dependency Treatment Benefits

Inpatient Residential Treatment Pre-authorization by Assistance Recovery Program (ARP) required	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers.
Outpatient Treatment Referral and pre-authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers. Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

Dental Benefits ⁽¹⁾	Coverage
Deductible	None
Diagnostic and Preventive Benefits	Plan pays 100% of allowed charge
Basic Benefits	Plan pays 85% of allowed charge
Restoration Benefits	Plan pays 85% of allowed charge
Prosthetic Benefits	Plan pays 60% of allowed charge
Calendar Year Maximum (does not apply to dependent children up to age 18)	\$2,500 per person
⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.	

Vision Benefits ⁽¹⁾⁽²⁾	VSP Providers	Non-VSP Providers
Copayment	\$7.50	\$7.50
Vision Examination – Limited to once every 12 months	Plan pays 100%	Plan pays up to \$45 per exam
Lenses – Limited to once every 12 months Single Vision Bifocal Trifocal Lenticular	Plan pays 100% up to network provider scheduled allowances	Plan pays up to: \$34 \$51 \$68 \$100
Frames – Limited to once every 24 months	Up to \$140 retail frame allowance	\$70
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in full	Plan pays up to \$210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to \$100 for exam and lenses	Plan pays up to \$100 for exam and lenses
Primary EyeCare Benefit (visits for the detection and treatment of medical conditions of the eye that are not just vision problems)	\$20 copay per office visit	Not covered
⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.		
⁽²⁾ Limitations on frequency of services do not apply to VSP Provider services for children under age 18.		

Plan C Schedule of Benefits

Schedule of Benefits – Effective January 1, 2012. All benefits are payable after the deductible is satisfied for the calendar year unless the Schedule indicates the deductible is waived for the service. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers. The benefits shown in the “Out-of-Area” column apply only when the Eligible Individual lives more than 30 miles from the nearest Contract Provider; they will also apply when the Eligible Individual is temporarily away from home on vacation or attending school.

Comprehensive Medical Benefits — Plan C			
Annual Maximum	\$2,000,000 per person, per calendar year (starting January 1, 2014 there will be no annual overall dollar maximum)		
Annual Deductible	\$750 per person; \$2,250 family maximum Deductible does not apply to Contract Provider and out-of-area office visits, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, the adult physical exam benefit for Non-Contract Providers, or out-of-area preventive care for children.		
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit		
Annual Coinsurance Limit	\$30,000 per person (of Allowed Charges). Deductible amounts do not apply toward meeting limit		
Benefit Description	Contract Provider	Non-Contract Provider+	Out-of-Area+
Inpatient Hospital (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Hospital Emergency Room for an Emergency Medical Condition	Plan pays 80%, no deductible; subject to coinsurance limit	Plan pays 80%, no deductible; subject to coinsurance limit	Plan pays 80%, no deductible; subject to coinsurance limit
Ambulatory Surgery Facility / Outpatient Hospital for Surgery	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Other Outpatient Hospital	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Physician Office Visits	After \$15 Copayment per visit, Plan pays 100%; no deductible	After deductible, Plan pays 60%	After \$15 Copayment per visit, Plan pays 80%; no deductible
Physician Hospital Visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit

+ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan C	Contract Provider	Non-Contract Provider⁺	Out-of-Area⁺
Speech Therapy ¹ Calendar Year Maximum: \$1,000 Lifetime Maximum: \$2,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Occupational Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Preventive Care for Children	Plan pays 100% for services required to be covered under Health Care Reform, no deductible	After deductible, Plan pays 60%	After \$15 Copayment per visit, Plan pays 80%; subject to coinsurance limit; no deductible
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform, no deductible	Plan pays 100% for a routine physical exam, up to \$150 per exam, no deductible	Plan pays 100% for a routine physical exam, up to \$150 per exam, no deductible
Preventive Care for Women including Pregnant Women	Plan pays 100% for services required to be covered under Health Care Reform, no deductible (including screening mammograms)	Plan pays 100% for a routine physical exam, up to \$150 per exam, no deductible Mammograms: After deductible, Plan pays 60%	Plan pays 100% for a routine physical exam, up to \$150 per exam, no deductible Mammograms: After deductible, Plan pays 80%; subject to coinsurance limit
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Skilled Nursing Facility Calendar Year Maximum: 180 days (admission must be within 14 days of discharge from a hospital)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Ambulance	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%	After deductible, Plan pays 80%; subject to coinsurance limit

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan C	Contract Provider	Non-Contract Provider+	Out-of-Area+
Durable Medical Equipment, Prosthetic Devices, and Home IV Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
TMJ Treatment Non-Surgical Lifetime Maximum: \$1,500	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Inpatient Mental Illness (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%	After deductible, Plan pays 80%; subject to coinsurance limit
Outpatient Mental Illness for covered providers only	Professional charges: After \$15 Copayment per visit, Plan pays 100%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, Plan pays 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After \$15 Copayment per visit, Plan pays 80%; no deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%	After deductible, Plan pays 80%; subject to coinsurance limit
¹ Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.			

+ All payments for Non-Contract Providers are based on the Allowed Charge.

Prescription Drug Benefits	
Not subject to annual deductible	
Participating Retail Pharmacy	Your Copayment for each prescription: Generic Drug: \$20 Brand Name Drug: \$40 Maximum Supply: 34 days
Mail Order Program:	Your Copayment for each prescription: Generic Drug: \$40 Brand Name if a Generic is available: \$80 Maximum Supply: 90 days
<p>If the actual cost of the prescription is less than the Copayment, you pay the actual cost.</p> <p>If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent, the remaining amount will be your responsibility, in addition to your Copayment.</p>	

Hearing Aid Benefit	
Hearing Examination	Plan pays 80% of Allowed Charge
Hearing Aid	Plan pays 80% of Allowed Charges (limited to one device per ear in any 3-year period)
Maximum Benefit	\$450 per ear

Chemical Dependency Treatment Benefits	
Inpatient Residential Treatment Pre-authorization by Assistance Recovery Program (ARP) required	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers.
Outpatient Treatment Referral and pre-authorization by ARP is recommended so that you can be directed to Contract Providers. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers. Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

Dental Benefits ⁽¹⁾	Coverage	
Deductible	None	
Diagnostic and Preventive Benefits	Plan pays 100% of allowed charge	
Basic Benefits	Plan pays 85% of allowed charge	
Restoration Benefits	Plan pays 85% of allowed charge	
Prosthetic Benefits	Plan pays 60% of allowed charge	
Calendar Year Maximum (does not apply to dependent children up to age 18)	\$2,500 per person	
Vision Benefits ⁽¹⁾⁽²⁾	VSP Providers	Non-VSP Providers
Copayment	\$7.50	\$7.50
Vision Examination – Limited to once every 12 months	Plan pays 100%	Plan pays up to \$45 per exam
Lenses – Limited to once every 12 months Single Vision Bifocal Trifocal Lenticular	Plan pays 100% up to network provider scheduled allowances	Plan pays up to: \$34 \$51 \$68 \$100
Frames – Limited to once every 24 months	Up to \$140 retail frame allowance	\$70
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in full	Plan pays up to \$210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to \$100 for exam and lenses	Plan pays up to \$100 for exam and lenses
Primary EyeCare Benefit (visits for the detection and treatment of medical conditions of the eye that are not just vision problems)	\$20 copay per office visit	Not covered
<p>⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.</p> <p>⁽²⁾ Limitations on frequency of services do not apply to VSP Provider services for children under age 18.</p>		

Plan D Schedule of Benefits

Schedule of Benefits – Effective January 1, 2012. All benefits are payable after the deductible is satisfied for the calendar year unless the Schedule indicates the deductible is waived for the service. The payment percentages shown are based on the negotiated fee for Contract Providers, or on the Allowed Charge for Non-Contract Providers.

Comprehensive Medical Benefits – Plan D		
Annual Maximum	\$2,000,000 per person, per calendar year (starting January 1, 2014 there will not be an annual overall dollar maximum)	
Annual Deductible	\$500 per person; \$1,000 family maximum Deductible does not apply to Contract Provider physician office visits, emergency room charges for an Emergency Medical Condition, Contract Provider preventive care covered under health care reform, or the adult physical exam benefit for Non-Contract Providers.	
Emergency Room Deductible	\$50 per visit (waived if admitted)	
Coinsurance	Plan pays the percentage shown below; subject to coinsurance limit	
Annual Coinsurance Limit Contract Providers only	\$15,000 per person, maximum \$30,000 family (of Allowed Charges), deductible amounts do not apply toward meeting limit. Does not apply to Non-Contract Providers. (This means that your annual out-of-pocket limit is \$3,000 or a maximum of \$6,000 per family.)	
Benefit Description	Contract Provider	Non-Contract Provider⁺
Inpatient Hospital (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Hospital Emergency Room for an Emergency Medical Condition	After annual deductible and emergency room deductible, Plan pays 80%; subject to coinsurance limit	After annual deductible and emergency room deductible, Plan pays 80%; subject to coinsurance limit
Ambulatory Surgery Facility	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%, subject to \$1,000 maximum per visit
Other Outpatient Hospital	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60% (Emergency room deductible applies if emergency room used for other than an Emergency Medical Condition)
Physician Office Visits	After \$20 Copayment per visit, Plan pays 100%; no annual deductible	After deductible, Plan pays 60%
Physician Hospital Visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Surgeon, Assistant Surgeon, Anesthesiologists, Outpatient X-ray and Laboratory Services, Radiation Treatment, Chemotherapy, Dialysis	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Speech Therapy ¹ Calendar Year Maximum: \$1,000 Lifetime Maximum: \$2,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.

Benefit Description – Plan D	Contract Provider	Non-Contract Provider⁺
Occupational Therapy	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Preventive Care for Children	Plan pays 100%, no deductible	After deductible, Plan pays 60%
Preventive Care for Men	Plan pays 100% for services required to be covered under Health Care Reform, no deductible	Plan pays 100%, up to \$250 per exam
Preventive Care for Women	Plan pays 100% for services required to be covered under Health Care Reform, no deductible (including screening mammograms)	Plan pays 100%, up to \$250 per exam Mammograms: After deductible, Plan pays 60%
Adult Immunizations	CDC recommended immunizations covered under Preventive Care for Men and Women above	After deductible, Plan pays 60%
Chiropractic Services and Physical Therapy Calendar Year Maximum: 40 visits (combined maximum for all services)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Acupuncture Weekly Maximum: 1 visit Per Diagnosis Maximum: 12 weeks	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Skilled Nursing Facility Calendar Year Maximum: 100 days	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Home Health Care Daily Maximum: 1 visit Calendar Year Maximum: 60 visits	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Ambulance	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%
Durable Medical Equipment / Prosthetic Devices Calendar Year Maximum: \$3,000	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
TMJ Treatment Non-Surgical Lifetime Maximum: \$1,500	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Inpatient Mental Illness (pre-authorization required)	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Outpatient Mental Illness for covered providers only	Professional charges: After \$20 Copayment per visit, Plan pays 100%; no annual deductible Outpatient facility charges: Paid the same as Other Outpatient Hospital	Professional charges: After deductible, Plan pays 60% Outpatient facility charges: Paid the same as Other Outpatient Hospital
Other Covered Expenses Not Shown Above	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 80%
¹ Speech therapy calendar year and lifetime maximums do not apply to a Physician's evaluation or to benefits provided to an Eligible Individual who had normal speech at one time but lost it due to Illness or Injury.		

⁺ All payments for Non-Contract Providers are based on the Allowed Charge.
Plan D

Prescription Drug Benefits	
Not subject to annual deductible	
Participating Retail Pharmacy	Your Copayment for each prescription: Generic Drug: \$20 Brand Name Drug: \$40 Maximum Supply: 34 days
Mail Order Program:	Your Copayment for each prescription: Generic Drug: \$40 Brand Name if a Generic is available: \$80 Maximum Supply: 90 days
<p>If the actual cost of the prescription is less than the Copayment, you pay the actual cost.</p> <p>If you have your prescription filled with a brand name drug when a generic equivalent is available, the Fund will only pay up to the reasonable cost of the generic equivalent, the remaining amount will be your responsibility, in addition to your Copayment.</p>	

Hearing Aid Benefit	Contract Provider	Non-Contract Provider+
Hearing Aids and Examination	After deductible, Plan pays 80%; subject to coinsurance limit	After deductible, Plan pays 60%
Maximum Benefit	\$500 per ear in any 36-month period	

Chemical Dependency Treatment Benefits	
Inpatient Residential Treatment Pre-authorization by Assistance Recovery Program (ARP) required	Paid the same as Inpatient Hospital for Contract and Non-Contract Providers.
Outpatient Treatment Referral and pre-authorization by ARP is recommended so that you can be directed to a Contract Provider. The Plan will not cover services that are determined by ARP to be not Medically Necessary.	Professional charges: Paid the same as Physician Visits for Contract and Non-Contract Providers. Facility charges: Paid the same as Other Outpatient Hospital for Contract and Non-Contract Providers

Dental Benefits ⁽¹⁾	Coverage
Deductible	None
Diagnostic and Preventive Benefits	Plan pays 100% of allowed charge
Basic Benefits	Plan pays 85% of allowed charge
Restoration Benefits	Plan pays 85% of allowed charge
Prosthetic Benefits	Plan pays 60% of allowed charge
Calendar Year Maximum (does not apply to dependent children up to age 18)	\$2,500 per person

⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.

Vision Benefits ⁽¹⁾⁽²⁾	VSP Providers	Non-VSP Providers
Copayment Vision Examination – Limited to once every 12 months	\$7.50 Plan pays 100%	\$7.50 Plan pays up to \$45 per exam
Lenses – Limited to once every 12 months Single Vision Bifocal Trifocal Lenticular Frames – Limited to once every 24 months	Plan pays 100% up to network provider scheduled allowances Up to \$140 retail frame allowance	Plan pays up to: \$34 \$51 \$68 \$100 \$70
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in full	Plan pays up to \$210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to \$100 for exam and lenses	Plan pays up to \$100 for exam and lenses
Primary EyeCare Benefit (visits for the detection and treatment of medical conditions of the eye that are not just vision problems)	\$20 copay per office visit	Not covered
<p>⁽¹⁾ You are eligible for dental and vision benefits only if your employer makes the required contribution for this coverage. Contact the Fund Office if you are not sure if you are eligible for these benefits.</p> <p>⁽²⁾ Limitations on frequency of services do not apply to VSP Provider services for children under age 18.</p>		

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