

MEDICAL BENEFITS

SCHEDULE OF MEDICAL BENEFITS

Eligibility Waiting Period: Coverage takes effect on the first of the month following the date of eligibility as provided herein.

Benefit Period: January 1 through December 31

The Plan provides benefits through the HealthLink Open Access III program. Under this arrangement, benefit levels vary with the network status of the provider **you** use. The highest benefits are paid when **you** use Health Maintenance Organization (HMO) providers, while slightly lower benefits are paid when **you** use Preferred Provider Organization (PPO) providers. Benefits are further reduced when **you** use Non-Network providers.

Although the highest level of benefits in the HealthLink Open Access III program is payable when using "HMO" Providers, it is not a traditional HMO. **You** do not have to select a primary care physician or obtain referrals to see specialists. **You** do not have to choose to be in the HMO or PPO; **you** are free to use any provider at any time.

In addition to its contract with HealthLink, the Fund has a contract with the USA Managed Care's PPO for geographic areas not serviced by HealthLink. Benefits for covered services obtained from USA network providers will be paid at the PPO benefit level shown in the Schedule of Benefits.

The "Out of Area" benefit level will be payable when there are no HMO or PPO providers available within 50 miles to provide necessary treatment.

A separate listing of HMO and PPO providers will be provided to **you** automatically without charge, however in order to ensure that **you** obtain the most up-to-date information available, **you** should contact HealthLink or USA at the telephone number listed on your medical identification card to determine whether your Physician, Hospital or other health care provider is a participating member of the network. Participating provider listings are also available on the Internet at www.healthlink.com or www.usamco.com.

Covered services obtained from a non-network provider will be covered at the PPO benefit level if treatment is for an accident or **emergency** medical condition as defined in this Plan and care cannot be obtained from an HMO or PPO provider without jeopardizing the patient's health.

Plan **Lifetime** Medical Maximum: \$1,000,000 per individual

The above maximum is applicable to all benefits for expenses listed as covered medical expenses under this Plan. The term “lifetime” refers to the time a person is actually covered under this Plan and is not intended to suggest benefits beyond an individual's termination date or the Plan’s termination date.

The following Plan benefits will vary depending on whether services are obtained from an HMO, PPO or Non-Network provider.

Cash Deductible (Per Calendar Year):

	<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out-of-Area</u>
<i>Individual</i>	\$150	\$150	\$200	\$200
<i>Family</i>	\$300	\$300	\$400	\$400

The cash **deductible** is the amount of covered expenses which must be incurred in a calendar year before benefits are payable for covered medical expenses incurred during the remainder of that year. It is in excess of any amount paid under any other benefit provisions of this Plan.

Although each covered expenses for each individual are subject to the **deductible**, the total amount required for **you** and all of **your dependents** combined will not be more than the "family" amount shown above.

Note: Expenses applied to the **deductible** for any provider category will also be applied to the **deductible** requirement for the other provider categories. For example: If you incur expenses of \$100 from a PPO Provider, your remaining deductible will be \$50 for HMO and PPO Providers and \$100 for Non-Network and Out-of-Area Providers. If you incur \$200 in expenses from a Non-Network provider your deductible will be satisfied for all other providers.

Out-Of-Pocket Maximum (Per Calendar Year Including the Deductible):

	<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out-of-Area</u>
<i>Individual</i>	\$1,000	\$2,000	Unlimited	\$2,000
<i>Family</i>	\$1,000	\$2,000	Unlimited	\$2,000

Once **you** and/or **your dependents** have paid the **out-of-pocket maximum** amount shown above during any calendar year, the Plan will pay eligible covered expenses incurred during the remainder of that calendar year at 100%.

The **out-of-pocket maximum** does not include mental and nervous/substance abuse treatment expenses, expenses incurred due to reduction to the **UCR** payment level or other non-covered expenses.

Note: No matter which provider **you** or **your dependents** use (HMO, PPO, Non-Network or Out of Area), all **co-payments** and **co-insurance** will be used to satisfy any Out-Of-Pocket limit (e.g., HMO **co-payments** will apply towards the PPO **out of pocket maximum**).

Medical Benefits Payable

The following table is a summary of medical benefits payable under the Plan.

For a complete description of covered medical expenses, as well as any exclusions and limitations, please refer to the "Covered Medical Expenses" and "Medical Exclusions and Limitations" sections. All services are subject to the applicable calendar year deductible, unless otherwise noted.

Services	Limitations	Benefit Percentage			
		<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out of Area</u>
Hospital Services:					
Inpatient	Semi-Private Room	100%	90%	70%	90%
Outpatient		100% after \$25 Co-pay	90% after \$25 Co-pay	Not Covered	90% after \$25 Co-pay
Emergency Room*		100% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)	70% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)
Physician Services:					
Office Visits		100% after \$10 Co-pay	100% after \$20 Co-pay	70%	90%
Other Physician Services*		100%*	90%*	70%*	90%*
Wellness Benefit: Includes: --Routine Physical Exam --Breast and Pelvic Exam --Routine Mammogram --Immunizations --Well Child Care --PSA Test for Men over age 40	\$250 Calendar Year Max. up to age 50; \$500 Calendar Year Max. age 50 and over	100% No Deductible	100% No Deductible	Not Covered	100% No Deductible
Chiropractic Care	\$1,000 Calendar Year Max.	100%	90%	70%	90%
Private Duty Nursing		100%	90%	70%	90%
Skilled Nursing Facility	Semi-Private Room	100%	90%	70%	90%

Services	Limitations	Benefit Percentage			
		HMO	PPO	Non-Network	Out of Area
Rehabilitation Facility	Semi-Private Room	100%	90%	70%	90%
Physical Therapy		100%	90%	70%	90%
Occupational Therapy		100%	90%	70%	90%
Speech Therapy		100%	90%	70%	90%
Home Health Care		100%	90%	70%	90%
Hospice Care	Semi-Private Room	100%	90%	70%	90%
Treatment of Infertility	\$2,500 Max. per Calendar Year \$10,000 Max. Lifetime	100%	90%	70%	90%
TMJ Treatment	\$1,500 Max. per Calendar Year	100%	90%	70%	70%
Mental Health & Substance Abuse Treatment:	\$10,000 Maximum per Calendar Year for Substance Abuse Treatment (Combined Inpatient and Outpatient)				
Inpatient	Limited to 30 Days per Calendar Year	N/A	90%	70%	90%
Outpatient	Limited to 40 visits per Calendar Year	N/A	80%	50%	80%
Participant Vision Benefit	\$150 Max. Benefit per Calendar Year; For Participants Only	100% No Deductible	100% No Deductible	100% No Deductible	100% No Deductible
All Other Covered Expenses (except as otherwise noted)		100%	90%	70%	90%

*Charges made by an emergency room physician, radiologist, pathologist or anesthesiologist will be paid based on the network participation of the facility at which services are received.