

# Base Plan for Active Employees

## Schedule of Benefits for Active Employees and Their Eligible Dependents with Base Plan Coverage

Effective June 1, 2022

<b>DEATH BENEFITS – EMPLOYEE ONLY</b>	
Active Employees' Death Benefit	\$20,000
<b>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY</b>	
Active Employees' Accidental Death and Dismemberment Benefit	\$20,000
<b>WEEKLY INCOME BENEFIT</b>	
<b>Weekly Benefits</b>	
• First 6 Weeks	\$390
• 7th through 12th Week	\$520
• 13th through 26th Week	\$650
<b>Maximum Number of Weeks Payable</b>	26 Weeks
<b>Benefits begin:</b>	
• Disability due to Injury	1st day of Disability
• Disability due to Sickness	8th day of Disability
<ul style="list-style-type: none"> <li>• If Disability due to Sickness lasts more than 8 weeks, the Plan will retroactively pay benefits for the first week of Disability.</li> <li>• Treatment resulting from an Accident must occur within 14 days of the Accident.</li> <li>• Disabilities lasting longer than 13 weeks are subject to large case management review.</li> </ul>	
<b>COMPREHENSIVE MAJOR MEDICAL BENEFITS</b>	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
<b>Calendar Year Maximum</b> (applies to Covered Expenses)	Unlimited
<b>Calendar Year Deductible</b>	
• Individual Deductible	\$600
• Family Maximum Deductible	\$1,800
<b>Coinsurance</b>	
• PPO Provider	90% of first \$19,000 of Individual Allowable Charges, 100% thereafter
• Non-PPO Provider	75% of first \$7,600 of Individual Allowable Charges, 100% thereafter
<b>Calendar Year Out-of-Pocket Maximum, after Deductible</b>	
• Individual	\$1,900
• Family Maximum	\$3,800
<b>Non-Accident Emergency Room Deductible</b> (does not apply to Deductible or Out-of-Pocket Maximum)	\$60 per visit after first two visits per Calendar Year

<p><b>Physician Office Visits</b>  Copayment (does not apply to Deductible or Out-of-Pocket Maximum)</p>	\$15 per visit
<p><b>Specialist Office Visits</b>  Copayment (does not apply to Deductible or Out-of-Pocket Maximum)</p>	\$15 per visit
<p><b>Chiropractic Treatment</b></p> <ul style="list-style-type: none"> <li>• Coinsurance paid by Plan</li> <li>• Calendar Year Maximum</li> <li>• Calendar Year Out-of-Pocket Maximum</li> </ul>	<p>50%  48 visits  None</p>
<p><b>Temporomandibular Joint Dysfunction (TMJ)</b></p> <ul style="list-style-type: none"> <li>• Coinsurance Plan Pays</li> <li>• Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.)</li> </ul>	<p>75%  \$3,500</p>
<p><b>Testosterone Replacement Therapy</b>  Calendar Year Maximum  (requires verification of Medical Necessity and lab results showing deficiency)</p>	\$2,500
<p><b>Growth Hormone Therapy</b></p> <ul style="list-style-type: none"> <li>• Lifetime Maximum (subject to Medical Necessity)</li> <li>• Lifetime Maximum for Dependent Child (subject to Medical Necessity)</li> </ul>	<p>No maximum  No maximum</p>
<p><b>Physical/Massage/Speech/Occupational/Acupuncture Therapy</b></p> <ul style="list-style-type: none"> <li>• Physical/Massage/Acupuncture Therapy Calendar Year Maximum</li> <li>• Speech Therapy Calendar Year Maximum</li> <li>• Occupational Therapy Calendar Year Maximum</li> </ul> <p>(Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)</p>	<p>48 visits  48 visits  48 visits</p>
<p><b>Hearing Aid Benefit</b></p> <ul style="list-style-type: none"> <li>• For Participants and Dependents age 18 and over (no maximum for Dependents under age 18)</li> <li>• EPIC Hearing Service Plan</li> </ul>	<p>\$1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020)</p> <p>Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries</p>

<b>ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)</b>	
<p>Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare &amp; Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when a non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.</p>	
<b>Organ Transplant Calendar Year Deductible</b> Individual Deductible	Major Medical Deductible of \$600
<b>Organ Transplant Coinsurance</b>	
<ul style="list-style-type: none"> <li>• COE Facility</li> <li>• Non-COE Facility</li> </ul>	90% of first \$15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges
<b>Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible</b>	
<ul style="list-style-type: none"> <li>• COE Facility</li> <li>• Non-COE Facility</li> </ul>	Major Medical Out-of-Pocket Maximum of \$1,900 No Out-of-Pocket Maximum
<b>Organ Transplant Immunosuppressive Medications</b>	See "Specialty Medications"
<b>Organ Procurement Benefit</b>	\$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities (effective October 1, 2020) Not subject to Deductible
<b>Organ Transplant Transportation/Lodging</b>	\$10,000 (effective October 1, 2020)
<b>BEHAVIORAL HEALTH BENEFITS</b>	
<p>Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).</p>	
<b>EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM</b>	
3 EAP Counseling Sessions	Plan pays 100%
<b>PRESCRIPTION DRUG BENEFITS</b>	
<b>Prescription Drug Deductible per Calendar Year per Person</b>	\$60
<b>Participating Retail Pharmacy Copayment up to a 34-day supply:<sup>1</sup></b>	
<ul style="list-style-type: none"> <li>• Generic Prescription</li> <li>• Brand Name Prescription</li> </ul>	\$15 \$20 <sup>2</sup>
<b>Non-Participating Retail Pharmacy Coinsurance</b>	50%
<b>Mail-Order Program Copayment up to a 90-day supply:</b>	
<ul style="list-style-type: none"> <li>• Generic Prescription</li> <li>• Brand Name Prescription</li> </ul>	\$25 \$35 <sup>2</sup>

<b>Specialty Medications<sup>3</sup></b>	10% Coinsurance, up to a maximum of \$125 per prescription fill for a 34-day supply <sup>4</sup>
<p><sup>1</sup> For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.</p> <p><sup>2</sup> Plus difference in cost between the generic and brand name prescriptions when a generic is available.</p> <p><sup>3</sup> Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p> <p><sup>4</sup> Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.</p>	
<b>DENTAL BENEFITS*</b>	
<b>Maximum Benefit per Person age 19 and older</b>	\$1,500 per Calendar Year
<b>Maximum Benefit per Person under age 19</b>	Unlimited
<b>Coinsurance</b> <ul style="list-style-type: none"> <li>• Type I</li> <li>• Type II</li> <li>• Type III</li> <li>• Orthodontia</li> </ul>	90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of \$2,000
<b>VISION BENEFITS*</b>	
<b>Coverage for each Covered Person age 19 and older includes:</b>	Calendar year eye exam, lenses, frames, and contact lenses
<b>Maximum Benefit per Calendar Year for each Covered Person age 19 and older</b>	\$400 maximum
<b>Coverage for each Covered Person under age 19 includes:</b>	Eye exams and materials related to vision correction, including any one of the following options: <ol style="list-style-type: none"> <li>a. Frames and lenses</li> <li>b. Contact lenses</li> <li>c. One set of frames and a one-year supply of contact lenses</li> </ol>
<b>Maximum Benefit per Calendar Year for each Covered Person under age 19</b>	No dollar maximum
<b>EXCLUDED PROVIDERS</b>	
<b>The Fund will not pay claims from the following out-of-network providers:</b>	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

\* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.