SCHEDULE OF BENEFITS
JANUARY 1, 2024

Quality Preferred Provider Organizations have agreed to discount services provided to Plan Participants by participating Preferred Providers, reducing benefit costs for both the Plan and the participant. The higher coinsurance for care provided by non-Preferred Providers does not begin to cover the increased costs to the Plan when using a non-Preferred Provider. Exceptions apply in the case of certain surprise medical bills as explained on page 42.

COMPREHENSIVE MEDICAL BENEFITS: (The annual deductible applies to this page.)

	Preferred Providers	Non-Preferred Providers
Deductible	$350.00 per individual/ $700.00 per family Deductible increased to $425.00 per individual (up to $850.00 per family) if the Eligible Participant and/or the Eligible Participant's spouse fail to complete no-charge physical examination and biometric screening in prior or current Plan Year	$350.00 per individual/ $700.00 per family Deductible increased to $425.00 per individual (up to $850.00 per family) if the Eligible Participant and/or the Eligible Participant's spouse fail to complete no-charge physical examination and biometric screening in prior or current Plan Year
Coinsurance	The Plan will pay 80% of allowed charges after the deductible has been met, up to $37,500.00 out-of-pocket per calendar year, per family and 100% in excess of $37,500.00.	The Plan will pay 50% of allowed charges after the deductible has been met, up to $37,500.00 out-of-pocket per calendar year, per family and 100% in excess of $37,500.00.
	Any billed charge that exceeds the allowable charge will be the participant's sole responsibility and will not count toward the deductible or the participant's coinsurance responsibility.	
Organ and/or tissue transplants	Limited to kidneys, liver, lung, bone marrow, and heart transplant.	
CHIROPRACTIC: Limited to twelve (12) visits per calendar year.		
NERVOUS & MENTAL CARE:		
	Preferred Provider	Non-Preferred Provider
Coinsurance	The Plan will pay 80% of allowed charges.	The Plan will pay 50% of allowed charges.
QUALIFIED ALCOHOL & DRUG TREATMENT:		
	Preferred Provider	Non-Preferred Provider
Coinsurance	The Plan will pay 80% of allowed charges. <u>All benefits for residential or Inpatient treatment must be pre-certified.</u>	The Plan will pay 50% of allowed charges. <u>All benefits for residential or Inpatient treatment must be pre-certified.</u>
Emergency Room Co-Pay	$150.00 per visit. This amount is in addition to the deductible and the participant's coinsurance responsibility.	
Dietician	1 visit per month	

Centers of Excellence	No deductible, coinsurance, or copayment shall apply for surgeries or musculoskeletal care provided through a Centers of Excellence program approved by the Board of Trustees. For more information about Centers of Excellence, contact the Fund Office.

DENTAL: DELTA DENTAL 800-234-3375

	Delta PPO	Delta Premier
Deductible	$25.00 per person/per year	$25.00 per person/per year
Coinsurance – General	The Plan will pay 90% of negotiated charges.	The Plan will pay 50% of PPO fee schedule.
Examination and Cleaning	The Plan will pay 100% of the contracted rate. 2 per year	The Plan will pay 50% of PPO fee schedule. 2 per year
Orthodontic Lifetime Maximum	$1,600.00 per individual; Lifetime maximum does not apply to Medically Necessary orthodontia coverage for Eligible Persons under the age of 19.	
Annual Maximum for Dental Benefits (including Orthodontic benefits)	$2,000.00 per individual / $4,000.00 per family. The annual maximum does not apply to Eligible Persons under the age of 19.	

OPTICAL: Vision Service Plan (1-800-877-7195) – Routine Vision Only

Eye exam every 12 months, spectacle lenses or contact lenses every 12 months, and frames every 24 months. Eye exam co-payment $10.00, lenses and frame co-payment $25.00. $120 allowable for Frames anything over allowance is patient responsibility. Safety glasses – member only - $25 co-pay $65 allowance- lenses every 12 months frames every 24 months. Anything over the $65 allowance is patient responsibility. Anything over $120 there is a 20% savings.
The Plan has signed an agreement with a preferred provider network for vision correction procedures. The Plan will pay up to $2,000.00 per person per lifetime for vision correction surgery.

PRESCRIPTION DRUGS:

	30 day	90 day
Generic Diabetic Drugs	No co-pay	
Generic Preventive Maintenance Drugs	No co-pay	
Co-Pay – Generic Drugs	20% or $5.00, whichever is greater (not to exceed the full price of the drug)	$7.50
Co-Pay – Preferred (Formulary) Drugs	20% or $15.00, whichever is greater (not to exceed the full price of the drug)	$22.50
Co-Pay – Non-Preferred Brand Name Drugs	20% or $30.00, whichever is greater (not to exceed the full price of the drug)	$45.00

DEATH BENEFITS

Participant – Accidental Death and Dismemberment Principal Amount	$10,000.00
Participant Death Benefits	$10,000.00
Dependent Death Benefits	$5,000.00

DISABILITY BENEFITS (eligible participants only)

Loss of Time Rate	$300.00 gross amount per week, up to a maximum of 13 weeks
Long Term Disability Rate	$100.00 gross amount per month, up to a maximum of 60 months
Loss of Time and Long Term Disability benefits are subject to tax withholding.	

MASSAGE & ACUPUNCTURE BENEFITS

Massage and/or acupuncture benefits will be covered up to $500.00 per year subject to the co-pays.