

This is your newly, revised schedule of benefits under Welfare Plan D9A. The Trustees have revised the ambulance maximum benefit from \$6,000.00 to \$15,000.00; the transplant lifetime maximum to \$175,000 on certain procedures and removed the visit limitations on the chiropractic benefit. If there are any questions concerning this Plan, please contact the Welfare Trust toll free at (888) 739-6442.

NOTICE

Under the D9A Plan, any office visit is subject to a Co-pay. Your benefits are calculated in the following order:

1. Co-pay;
2. Deductible if not met; and
3. Appropriate Co-insurance.

D9-A Plan	
Doctor Office Visit	
Primary Care Physician	
	\$15 Co-pay, then deductible, then %'s
HMO	85%
PPO	75%
Non-Network	55%
Primary Care Providers are: 1. Family Practice, 2. General Practice, 3. Internal Medicine, 4. Pediatrics, and 5. OB/GYN. All other provider types are Specialists.	
Specialty Care	
	\$25 Co-pay, then Deductible, then %'s
HMO	85%
PPO	75%
Non-Network	55%

Mental Disorders	
	\$25 Co-pay, then Deductible, then %'s
HMO	85%
Non-Network	55%
Maximum inpatient days per calendar year	30 days
Maximum outpatient visits per calendar year	30 days

Substance Abuse	
	\$25 Co-pay, then Deductible, then %'s
HMO	85%
Non-Network	55%
Maximum inpatient days per calendar year	30 days
Maximum outpatient visits per calendar year	30 days
Lifetime Limit	\$20,000 lifetime maximum

St. Johns Mercy Managed Behavioral Health (Formally known as Unity Managed Mental Health) must be notified prior to seeking treatment for any mental or nervous disorder or any drug or alcohol problem. Please contact them at: (314) 729-4600 in St Louis, MO or 1-800-413-8008 (Toll-Free)

D9-A Plan	
Surgeon and Physician Services	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%
Outpatient Surgery	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%

Hospital Services	
Room and Board	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%
Maximum number of days	No Limit
Healthlink should be notified prior to any Inpatient Admissions, Ambulatory Service, Outpatient Surgery, Home Health Care, Durable Medical Equipment, and Rehab and Outpatient Physical Therapy. Please have admitting physician or member call HealthLink at: 1-877-284-0102 (Toll-Free Nationwide)	

Surgeon and Physician Services	
Diagnostic X-Ray and Lab	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%

Emergency Room	
	\$100 Co-pay, then Deductible, then the Plan Pays:
HMO	85%
PPO	75%
Non-Network	55%

Urgent Care Center	
	\$50 Co-pay, then Deductible, then the Plan Pays:
HMO	85%
PPO	75%
Non-Network	55%

D9-A Plan	
Specialty Drugs provided through PBM	No Deductible
	Member pays 20% up to \$150; Member out of pocket is limited to \$3,250 annually
	Chemotherapy drugs not subject to deductible or copay

Ambulance Service	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%
Maximum Benefit	\$15,000

Transplants	
	After Deductible
HMO	85%
PPO	75%
Non-Network	Not Covered
Lifetime Maximum Benefit per Procedure*	\$125,000 (prior to 07/01/2007); \$175,000 (effective 07/01/2007) (\$75,000 kidney)
Transplant Donor Expenses	Secondary to donor's coverage
* Transplants and Replacements Limited:	Heart; Lung; Heart and Lung; and Liver Transplant

Spinal Manipulation Chiropractic	
	No Deductible
Benefit Limits	30 visits per calendar year
Maximum benefit per calendar year	\$750
Maximum Benefit per Visit	\$25 per visit
X-rays and Diagnostic testing	Limited to \$150 annually (this is a part of the \$750 Benefit Maximum)

Speech Therapy	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%
Maximum Benefit	\$750 annual maximum 30 visits per calendar year
Visit Limit	\$25
	Covered as Restorative Only

D9-A Plan	
Physical Therapy	After Deductible
Benefit Limits	\$2,250 per 12 month period per condition
HMO	85%
PPO	75%
Non-Network	55%

Preventive Care	
Adult Routine Well Care	
For office visit and necessary lab/x- rays	After Deductible
Visit in connection	Co-pay, then deductible, then the %'s
HMO	85%
PPO	75%
Non-Network	55%
Benefit Limits	1 exam every calendar year
Pediatric Routine Well Care	
For office visit and necessary lab/x-rays	After Deductible
Visit in connection	Co-pay, then deductible, then the %'s
HMO	85%
PPO	75%
Non-Network	55%
Benefit Limits	1 exam every calendar year

Well Woman/Well Man	
Mammogram	
	After Deductible
HMO	85%
PPO	75%
Non-Network	55%
Benefit Limits	1 between ages 35-39; annually thereafter
Pap smears/Prostate Exams (PSA)	
	No Deductible
Visit in connection	Co-pay, then the %'s
HMO	85%
PPO	75%
Non-Network	55%

D9-A Plan	
Childhood Immunizations	
	No Deductible
Visit in connection	Co-pay, then the %'s
HMO	85%
PPO	75%
Non-Network	55%

Prescription Drug Benefit	
Retail Pharmacy	
Generic Drug Co-pay	20% of cost, min. of \$8 and max. of \$100
Formulary Brand Name Drug Co-pay	20% of cost, min. of \$20 and max. of \$100
Non-Formulary Brand Name Drug Co-pay	20% of cost, min. of \$35 and max. of \$100
Brand where Generic is available	50% of cost, \$1,250 annual limit for non-formulary brand drugs
Mail Order (90 Day Supply)	
Generic Drug Co-pay	13.33% of cost, min. of \$16 and max. of \$200
Formulary Brand Name Drug Co-pay	13.33% of cost, min. of \$40 and max. of \$200
Non-Formulary Brand Name Drug Co-pay	13.33% of cost, min. of \$70 and max. of \$200
Brand where Generic is available	50% of cost, \$1,250 annual limit for non-formulary brand drugs

Accidental Injuries	
Benefit	No annual deductible or co-insurance applies to covered charges incurred for treatment of an accidental injury that is provided during the 48 hours following the accident. Appropriate co-pay's apply.

D9-A Plan	
Vision Care Benefits	
Eye exam per person, in calendar year	
In-Network	100%
Non-Network	Up to \$36
Eyeglass lenses, per pair, in calendar year	
Single Vision	
In-Network	100%
Non-Network	Up to \$28
Lined Bifocal	
In-Network	100%
Non-Network	Up to \$45
Lined Trifocal	
In-Network	100%
Non-Network	Up to \$56
Eyeglass Frames	
Benefit Limits	1 every 24 months
In-Network	Up to \$120
Non-Network	Up to \$45
Contact Lenses	
Benefit Limits	1 every 12 months
In-Network	Up to \$120
Non-Network	Up to \$105

D9-A Dental Benefits	
Calendar Year Deductible	
Individual	\$100
Family	Not Limited
Routine Preventive	No Deductible, 80%
Basic Restorative	After Deductible, 80%
Major Dental	After Deductible, 50%
Maximum Annual Benefit	\$1,500
Orthodontics (up to age 18 Only)	50% co-pay, \$1,000 lifetime max.
Orthodontic services shall be deemed incurred on the date the service is received or rendered. Initial claim should include total fee, banding date, and length of treatment in months. The initial fee would be eligible on the date banded and the monthly adjustments should be billed monthly as incurred for the length of treatment. Appliances are eligible if the maximum benefit has not been previously reached.	