

FLEET OWNERS INSURANCE FUND
PLAN A
Schedule of Benefits
EFF. 1/1/2016

Benefits	Network	Out-of-Network
Benefit Plan	January 1 st through December 31 st	
Dependent Age Limit	26 Removal upon end of birth month	
Prescription Drugs (generic only unless none available), subject to formulary approved by the Trustees. Formulary is at www.fleetownersinsruance.org	Inpatient: 100% Generic:90% Non-Preferred Brand: 50%	Outpatient: 80% Preferred Brand: 80% Specialty: 50%
Plan Exceeds Minimum Value.	Plan A is a “grandfathered” plan under the ACA.	
Benefit Period Deductible- Single/Family ¹	\$200/\$400	\$400/\$800
Coinsurance	100% for most services	50% for most services
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$500/\$1,000	\$1,000/\$2,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$10 co-pay, then 100%	50% after deductible
Urgent Care Facility Services ²	\$10 co-pay, then 100%	50% after deductible
Voluntary Second Surgical Opinion	\$10 co-pay, then 100%	50% after deductible
Allergy Testing and Treatments	80% after deductible	50% after deductible
Standard Immunizations	80% after deductible	50% after deductible
Preventative Services		
Office Visit/Routine Physical Exam (one exam per benefit period)	100%	50% after deductible
Well Child Care Services including Exam and immunizations (To age nine) ²	\$10 co-pay, then 100%	50% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	50% after deductible
Routine PSA	100%	50% after deductible
Routine Mammogram (One per benefit period)	100%	50% after deductible
Routine Pap Test (One per benefit period)	100%	50% after deductible
Routine Gynecological Exam: Female Contract Holder or Spouse only; one per benefit period in conjunction with routine pap test	100%	50% after deductible
Routine Colon Cancer Screening, Colonoscopy (One per benefit period)	100%	50% after deductible
Ambulatory Patient Services		
Surgical Services (inpatient/outpatient; professional/institutional)	100% after deductible	50% after deductible
Radiology/Lab/Diagnostic Services	100% after deductible	50% after deductible
Physical & Speech Therapy- Facility	100% after deductible	50% after deductible
-Professional	80% after deductible	50% after deductible
Occupational Therapy-Facility	100% after deductible	50% after deductible
-Professional	80% after deductible	
Chiropractic Therapy-Professional Only (12 visits per benefit period)	80% after deductible	50% after deductible
Radiation, Chemotherapy, Respiratory, Pulmonary, Cardiac Rehab, Dialysis Treatment-Facility	100% after deductible	50% after deductible
Professional	80% after deductible	50% after deductible
Emergency Care (Accident/Medical Emergency)	100% deductible does not apply	
Non-Emergency use of an Emergency Room ^{3,4}	\$200 co-pay, then 80%	\$200 co-pay, then 50%

¹ Maximum family deductible. Member deductible is the same as single deductible.

² The office visit co-pay applies to the cost of the office visit only.

³ Co-pay waived if admitted.

⁴ The co-pay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

Benefits	Network	Out-of-Network
Inpatient Facility/Hospitalization		
Semi-Private Room and Board- including ancillaries & pre-admission testing (365 days)	100% after deductible	50% after deductible
Professional Services	80% after deductible	50% after deductible
Newborn care-Inpatient	100% after deductible	50% after deductible
Maternity Care	100% after deductible	50% after deductible
Skilled Nursing Facility (30 days per benefit period)	60% after deductible	50% after deductible
Hospice	80% after deductible	50% after deductible
Private Duty Nursing	60% after deductible	50% after deductible
Additional Services		
Anesthesia	100% after deductible	50% after deductible
Ambulance	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Home Healthcare (30 days per benefit period)	60% after deductible	50% after deductible
Organ Transplant (Employee only) including heart, lung, liver, pancreas, kidney, bone marrow, cornea	60% after deductible	50% after deductible
Case Management	100% deductible does not apply	
Podiatry Services	80% after deductible	50% after deductible
Mental Health and Substance Abuse- Federal Mental Health Parity		
Mental Health Inpatient Outpatient	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits
Substance Inpatient: 30 days (1 per benefit period) Outpatient: 30 visits per benefit period	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits
Chronic Disease Management	80% after deductible	50% after deductible

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LIFE/AD & D INSURANCE – ACTIVE EMPLOYEE

Life Benefits for Member.....\$30,000.00
Accidental Death and Dismemberment for Member (**excluding** Suicide).....\$30,000.00

LAST ILLNESS AND BURIAL EXPENSE

Spouse Benefit.....\$3,000.00
Children Benefit.....\$1,500.00

ACCIDENT AND SICKNESS WEEKLY BENEFIT NON-OCCUPATIONAL

Accident and Sickness Weekly Benefit for Participant—.....\$300.00 per week for the first 10 weeks
.....\$350.00 per week for the next 16 weeks
Waiting Period—Accidents.....Benefits begin on the first day after the accident
Illness.....Benefits begin on the 8th day after hospitalization
Maximum Benefit.....26 weeks

Notes: Services requiring a co-pay are not subject to the single/family deductible.
Coinsurance expenses incurred for services by an out-of-network provider will be separate from the network coinsurance out-of-pocket limits.
Benefits will be determined based on the Plan provisions, subject to appeal rights in the Plan Booklet.

FLEET OWNERS INSURANCE FUND
Plan A (Dentemax Network)
Traditional Dental Rider
with Orthodontia

Benefits	
Benefit Period	January 1 st through December 31 st
Dependent Age Limit	26 Removal upon end of birth month
Benefit Period Maximum (per member)	\$2000
Benefit Period Deductible (per member)	None
Orthodontic Lifetime Maximum (per eligible dependent up to age 19)	\$1,500
Preventative Services	
Oral Exams- two per benefit period	100% UCR
Bite Wing X-Rays- two sets per benefit period	100% UCR
Prophylaxis (cleaning)- two per benefit period	100% UCR
Fluoride Treatment- one treatment per benefit period, limited to dependents up to age 19	100% UCR
Space Maintainers-limited to eligible dependents up to age 19	100% UCR
Diagnostic X-rays	100% UCR
Essential/Restorative Services	
Consultations and Other Exams by Specialist	80% UCR
Apicoectomy Services	80% UCR
Minor Restorative Services	80% UCR
Endodontic/Pulp Services	80% UCR
Periodontal Services	80% UCR
Surgical Extractions	80% UCR
Simple Extractions	80% UCR
Alveoplasty	80% UCR
Impactions	80% UCR
Emergency Palliative Services	80% UCR
Minor Oral Surgery Services	80% UCR
General Anesthesia	80% UCR
Complex Services	
Prosthetic Repairs, Relines and Adjustments	60% UCR
Gold Foil Restoration	60% UCR
Inlays, Onlays- one every five years	60% UCR
Crowns- one every five years per tooth	60% UCR
Root Canals	60% UCR
TMJ: \$1000 Lifetime Maximum	60% UCR
Bridgework (Pontics & Abutments) – one every five years	60% UCR
Partial and Complete Dentures- one every five years	60% UCR

Benefits	
Orthodontic Services-Dependents up to age 19 only!	
Orthodontic Diagnostic Services	60% UCR
Minor Treatment for Tooth Guidance	60% UCR
Minor Treatment for Harmful Habits	60% UCR
Interceptive Orthodontic Treatment	60% UCR
Comprehensive Orthodontic Treatment	60% UCR

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Note: The Dental Program provides for all covered dental services including the examination and treatment charges.

Under this benefit plan, the Fund will provide 100% benefits for preventative services, a 80% benefit for Essential/Restorative services, a 60% benefit for Complex services and a 60% benefit for Orthodontic services [for dependents up to age 19 only]. Qualified participant and/or dependent is responsible for the remaining coinsurance.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. The contract or certificate will contain the complete listing of covered services.

In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

FLEET OWNERS INSURANCE FUND
Plan A
Vision Rider

Benefits	
Benefit Period	January 1 st through December 31 st
Dependent Age Limit	26 Removal upon end of birth month
Examinations	One per benefit period
Vision Examinations	\$75 per exam
Frames	One per benefit period
Basic Frames	\$125 per frame
Prescription Lenses	One per benefit period
Single Vision Lenses	\$125 per pair
Bifocal Lenses	\$125 per pair
Trifocal Lenses	\$125 per pair
Lenticular Single Lenses	\$125 per pair
Lenticular Bifocal Lenses	\$125 per pair
Lenticular Trifocal Lenses	\$125 per pair
Contacts in Lieu of Lenses	One per benefit period
Medically Necessary	\$150 per pair
Cosmetic	\$150 per pair

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*No coverage for glasses or contacts without a prescription.

Note: Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

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FLEET OWNERS INSURANCE FUND
Plan A
Hearing Rider

Benefit Description	Dollar Maximum	Frequency
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	26 Removal upon end of birth month	
Coinsurance	100%	
Audiometric Exam	\$50	1 per 24 months
Hearing Aid Evaluation	\$70	1 per 24 months
Hearing Aid (per ear)	\$400	1 per 24 months
Conformity Evaluation	Not Covered	

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Note: The Hearing product provides benefits for all covered hearing services including the examination, evaluation and hearing aid charges.

Under this benefit plan, the Fund will provide 100% benefit for Hearing services up to the specified dollar maximums. Qualified participant and or dependent is responsible for the remaining balance.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

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