SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan for eligible Participants and their eligible Dependents. These benefits are described in greater detail in the Summary Plan Description.

- The amounts charged for medical services provided by a BCBS in-network PPO provider are subject to the PPO contractual allowed amounts. You will not be balanced billed for amounts over the allowed contractual amount.
- The amounts charged for medical services provided by an out-of-network Non-PPO provider are subject to the Reasonable and Customary Allowances (R&C) as adopted by the Fund Office. You are responsible to pay for amounts over the Reasonable and Customary Allowance.
- Unless otherwise stated, all covered comprehensive medical benefits are subject to the applicable Deductible and Out–of-Pocket Maximum.
- PPO and Non-PPO Deductibles and Out-of-Pockets Maximums are separate and cannot be combined.

COMPREHENSIVE MEDICAL BENEFITS
Contracted Provider: BlueCross BlueShield of Illinois

	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
Co-Insurance	80% paid by Plan	60% paid by Plan
Deductible per calendar year	$300/Individual $900/Family	$600/Individual $1,800/Family
Out-of-Pocket Maximum per calendar year	$2,000/Individual $6,000/Family	$6,000/Individual $18,000/Family
	After a covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered expenses for the rest of the calendar year. PPO and Non-PPO Deductibles and Out of Pocket Maximums are separate and cannot be combined	
Penalty for Failure to Pre-certify a Hospital Admission	$500 per admission	
• **Ambulance Service**	80% paid by Plan	
• **Chiropractic Care**	80% paid by Plan	60% paid by Plan
	Maximum of $3,000 per Employee per Calendar Year Maximum of $1,000 per Spouse per Calendar Year No coverage for dependent children	
• **Bariatric Surgery (for weight loss)**	80% paid by Plan	60% paid by Plan
	The patient is required to contact the Fund Office **before** any treatment is given and **MUST** participate in ComPsych's Bariatric Support Service Program (BSSP) and be approved for surgery	
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan

• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**

	DBM Network Facilities	**BCBS PPO In-Network Hospitals or Free Standing Diagnostic Facilities**	**Non-PPO Out-of-Network Hospitals or Free Standing Diagnostic Facilities**
Plan Pays	**Free** - 100% paid by Plan	80%	60%
Deductible	None	Applies	Applies

	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room (Facility & Physician Fees)**	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-Payment**	$250 per Emergency Room Visit Waived if immediately admitted to the hospital	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 Days per Convalescent Period	
• **Genetic Testing**	See Preventive/Wellness Care Benefit	

<table>
<tr><td>• Hearing Benefit</td><td>EPIC Hearing Service (Hearing Aid Only)</td><td>BCBS In-Network PPO Provider</td><td>Out-of-Network Non–PPO Provider</td></tr>
<tr><td>o Hearing Evaluation/Exam</td><td colspan="3">Paid at 100% up to a $150 Maximum per Individual
once every two (2) consecutive Calendar Years
Deductible does not apply</td></tr>
<tr><td>o Hearing Aid Instrument</td><td colspan="3">Paid at 100% up to $2,500 Maximum per Individual
once every five (5) consecutive Calendar Years
Deductible does not apply</td></tr>
</table>

<table>
<tr><td></td><td>BCBS In-Network
PPO Provider</td><td>Out-of-Network
Non–PPO Provider</td></tr>
<tr><td rowspan="2">• Home Health Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Maximum of 120 Days per Convalescent Period</td></tr>
<tr><td>• Home Infusion Therapy (HIT) for the administration of an intravenous drug</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td rowspan="2">• Hospice Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Lifetime Maximum of 180 days per Individual</td></tr>
<tr><td rowspan="2">• Hospital, Inpatient & Outpatient Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Maximum 180 days per Calendar Year for In-patient services</td></tr>
<tr><td rowspan="2">• Infertility Services (Hospital, Physician, Drugs, Treatments, etc.)</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Combined Lifetime Maximum of $10,000 for services provided to the participant and spouse</td></tr>
<tr><td>• Maternity Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Organ Transplant</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Physical, Occupational and Speech Outpatient Therapy for Restorative/ Rehabilitative Therapy (up to 6 months to restore an established function)</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Dependent children through age 18)</td><td>80% paid by Plan up to a $9,000; thereafter the Plan pays 25% of the PPO allowance per Calendar Year</td><td>60% paid by Plan up to a maximum of $9,000 per Calendar Year</td></tr>
<tr><td colspan="3">• Preventive/Wellness Care</td></tr>
<tr><td rowspan="2">o Comprehensive Health Evaluation and Physical Exam (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostrate screening and more)</td><td colspan="2">Health Dynamics Provider</td></tr>
<tr><td colspan="2">Free to Participant and Spouse
100% paid by Plan once every Calendar Year.
Not available to dependent children</td></tr>
<tr><td></td><td>BCBS In-Network
PPO Provider</td><td>Out-of-Network
Non–PPO Provider</td></tr>
<tr><td>o Preventive/Wellness Care services (e.g., routine screenings, immunizations and counseling services) recommended by the U.S. Preventive Service Task Force for Grade A & B services (see www.healthcare.gov for list of services)</td><td>100% paid by Plan per Calendar Year. Deductibles and Co-Insurance Maximums do not apply</td><td rowspan="2">Maximum of $300 for In- and Out-of-Network providers will be paid by the Plan per Individual per Calendar Year. Deductible does not apply</td></tr>
<tr><td>o Other Preventive/Wellness Care services including genetic testing</td><td>Maximum of $300 for In- and Out-of-Network providers will be paid by the Plan per Individual per Calendar Year. Deductible does not apply</td></tr>
<tr><td>• Professional Fees (e.g., Doctor fees)</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Reconstructive Breast Surgery (following a mastectomy covered by the Plan)</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Second Surgical Opinion</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Surgical Assistants</td><td>80% paid by Plan</td><td>60% paid by Plan, limited to 20% of the surgeon’s charge</td></tr>
</table>

	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
• **Surgi-Center Facility – Hospital Affiliated**	80% paid by Plan	60% paid by Plan
• **Surgi Center Facility - No Hospital Affiliation**	80% paid by Plan	NO COVERAGE
• **Temporomandibular Joint Care** (TMJ)		
o Physician Services	80% paid by Plan	60% paid by Plan
	Subject to $2,000 Lifetime Maximum per Individual	
o Appliances, and their adjustments, for TMJ and Bruxism (Occlusal)	80% paid by Plan up to a $2,000 Lifetime Maximum. Subject to the $600/Individual or $1,800/Family Deductible	

BEHAVIORAL HEALTH & SUBSTANCE ABUSE BENEFITS

Contracted Provider: ComPsych, Guidance Resources

Note: The deductibles and out-of-pocket maximums listed below are in addition to the deductibles and out-of-pocket maximums listed under the Comprehensive Medical Benefit section.

	ComPsych In-Network	**Out of Network**
Co-Insurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300/Individual $900/Family	$600/Individual $1,800/Family
Out-of-Pocket Maximums per Calendar Year	$2,000/Individual $6,000/Family	$6,000/Individual $18,000/Family
Penalty for failure to Pre-certify	$500 per admission	
• **Ambulance Services**	80% paid by Plan	
• **Emergency Room**	80% paid by Plan	
• **Emergency Room Co-Payment**	$250 per Emergency Room Visit Waived if immediately admitted to the hospital	
• **Hospital Co-Insurance for In-Patient and Partial Hospitalization**	80% paid by Plan	60% Paid by Plan
• **Hospital Confinement Maximum**	180 days per Calendar Year for In-Patient and Partial Hospitalization combined	
• **Hospital Out Patient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Intensive Outpatient and Outpatient Treatments**	80% paid by Plan	60% paid by Plan
• **Member Assistance Program (MAP)**	5 **Free** Short term sessions	No coverage
• **Residential, Custodial or Group Homes**	No Coverage	

PRESCRIPTION BENEFITS

Contracted Provider: Medco Health Solutions

- All long term medications MUST be filled through Medco's mail order program. A maximum of three (3) fills are allowed at a retail pharmacy, thereafter long term medications will be covered by the Plan only when Medco's mail order program is used.

	Medco Network Retail Pharmacy (Lesser of 100 pills or a 30-day supply)	**Medco by Mail** (Up to a 90-day supply through mail order)	**Accredo, Medco's Specialty Pharmacy** (For specialty drugs)
Generic Co-Payment	$5	$12.50	n/a
Single-Source Brand Co-Payment (A generic is not available)	20% $10 minimum Co-Pay per drug with a $100 maximum Co-Pay	20% $25 minimum Co-Pay per drug with a $250 maximum	n/a
Multi-Source Brand Co-Payment (A generic is available)	35% $20 minimum Co-Pay	35% $50 minimum Co-Pay	n/a
Specialty Medications used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care	n/a		20% $20 minimum Co-Pay per drug with a $100 maximum Co-Pay

DENTAL BENEFITS Contracted Provider: Delta Dental of Illinois			
	Delta Dental PPO	**Delta Dental Premier**	**Out of Network**
Annual Maximum	$1,500	$1,500	$1,500
Annual Deductible (applies only to Basic and Major Care)	$50/Person $100/Family	$50/Person $100/Family	$50/Person $100/Family
Balance Billing (The difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. You are responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)** o Dependent Children through Age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the Annual Deductible or Annual Maximum	Paid at 100% of Delta Dental's Maximum Plan Allowance, not subject to the Annual Deductible or Annual Maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the Annual Deductible, but subject to the Annual Maximum
o Adults - Ages 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the Annual Deductible, but subject to the Annual Maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the Annual Deductible, but subject to the Annual Maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the Annual Deductible, but subject to the Annual Maximum
• **Basic Care (2)** o All Ages	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the Annual Deductible and the Annual Maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the Annual Deductible and the Annual Maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the Annual Deductible and the Annual Maximum
• **Major Care (3)** o All Ages	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the Annual Deductible and the Annual Maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the Annual Deductible and the Annual Maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the Annual Deductible and the Annual Maximum
• **Orthodontia** o Dependent Children through Age 18	The first $4,000 in orthodontia charges are paid at 50% with additional charges paid at 25% when services are rendered by a Delta Dental provider. Benefit payments will be reflective of any orthodontia payments made by the Fund or Delta Dental prior 07-01-2011. If you met the $2000 lifetime maximum benefit in that was in effect prior to 07-01-2011, all future orthodontia payments will be paid at 25%.		Paid at 80% of the dentist's usual fee subject to a Lifetime Maximum of $2,000
o Adults - Ages 19 and older	Paid at 80% of Delta Dental's PPO reduced fee schedule, subject to a Lifetime Maximum of $2,000	Paid at 80% of the dentist's usual fee subject to a Lifetime Maximum of $2,000	Paid at 80% of the dentist's usual fee subject to a Lifetime Maximum of $2,000
(1) Preventive/Diagnostic Care includes:			
✓ Oral Evaluations (two in 12 month period) ✓ Prophylaxis/Cleaning (two in a 12 month period)	✓ X-rays (bitewings two in a 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in a 24 month period)	✓ Fluoride Treatment (once in a 12 month period for dependent children through age 18)	✓ Palliative Treatment
(2) Basic Care includes:			
✓ Fillings ✓ Oral Surgery ✓ General Anesthesia	✓ Periodontics ✓ Endodontics ✓ Consultations	✓ Sealants (1st & 2nd Molars only, for dependent children through age 14)	✓ Space Maintainers ✓ Removal of cysts & tumors in the mouth
(3) Major Care (services are covered once in a 5 year period, to the day) include:			
✓ Crowns, Jackets & Case Restoration	✓ Fixed & Removable Bridges ✓ Partial & Full Dentures	✓ Veneers (Permanent Teeth Only)	✓ Implants and related services

Note: All Frequency limitations listed above are to the day.

VISION BENEFITS Contracted Provider: EyeMed Vision Care		
	EyeMed In-Network	**Out-of-Network**
Eye Exam	100% paid by Plan	$30 per Calendar Year
Standard Lenses	100% paid by Plan	$50 per Calendar Year
Frames	100% (up to $200 retail)	$50 per Calendar Year
Contacts	100% (up to $125 retail)	$75 per Calendar Year

WEEKLY BENEFITS FOR ILLNESS AND INJURY (For Employees Only)	
Non-Occupational (Not Work-Related)	A payment up to $450 per week and up to 40 Hours per week will be credited to health & welfare eligibility for each week of a certified disability for a maximum of 52 weeks
Occupational (Work Related)	Up to 40 Hours per week will be credited to health & welfare eligibility for each week of a certified disability for a maximum of 52 weeks

LIFE INSURANCE BENEFITS Contracted Provider: Aetna Life Insurance Company			
	Eligible Participant	**Spouse**	**Child**
Policy Amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE PARTICIPANTS ONLY Contracted Provider: Aetna Life Insurance Company				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000