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 later in the Summary Plan Description.

The amounts charged for medical expenses are subject to the Reasonable and Customary Allowances as adopted by the Fund Office. Amounts over the reasonable and customary allowance are the Covered Individual's responsibility.

MEDICAL/SURGICAL CONDITIONS

	BCBS In-Network PPO Hospital	Out-of-Network Non–PPO Hospital
HOSPITAL BENEFITS		
Blue Cross MSA Failure to Notify Penalty for Hospital Admission.	$500 per admission	
Hospital Coinsurance	100% paid by Plan	60% paid by Plan
Hospital Out-of-Pocket Maximum	$0	$3,000 per admission
Hospital Confinement Maximum	180 days per Calendar Year	
Hospital Outpatient Diagnostic Tests	100% paid by Plan	60% paid by Plan
Outpatient Hospital Surgi-Center Facility	100% paid by Plan	60% paid by Plan $3,000 Out-of-Pocket Maximum per admission applies
Outpatient Free Standing Surgi-Center Facility	100% paid by Plan	NO COVERAGE
Emergency Room	100% paid by Plan	
Emergency Room Co-Payment	$100 per Emergency Room Visit Waived if Immediately Admitted to the Hospital	
COMPREHENSIVE MEDICAL BENEFITS*		
	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
Lifetime Maximum	$2,000,000 per Individual	
Calendar Year Deductible	$200 per Individual $600 Family Maximum	$400 per Individual $1,200 Family Maximum
Coinsurance for Professional Charges, including Physician Fees and Other Medical Services	90% paid by Plan	60% paid by Plan *
Out-of-Pocket Maximums per Calendar Year for Professional Services	$1,000 per Individual $3,000 Family Maximum	$3,000 per Individual $9,000 Family Maximum
Ambulance Service	90% paid by Plan	
Chiropractic Care	90% paid by Plan	60% paid by Plan*
	Maximum of $3,000 per Individual per Calendar Year	
Bariatric Surgery (for weight loss)		
• Fund Office **MUST** be called before any treatment is given	Yes	
• Patient **MUST** participate in ComPsych's Bariatric Support Service Program (BSSP) and be approved for the surgery	Yes	
• Coinsurance for Medical Providers	90% paid by Plan	60% paid by Plan*
• Hospital Charges	100% paid by Plan	60% paid by Plan
• Out of Pocket Maximum	$	$3,000 per admission
Chiropractic Care	90% paid by Plan	60% paid by Plan*
	Maximum of $3,000 per Individual per Calendar Year	
Diagnostic X-Rays and Lab Tests (which are not performed at a Hospital) and the Reading and Interpretation of the x-ray or test when performed as an Inpatient or Outpatient	90% paid by Plan	60% paid by Plan*
	PPO and Non-PPO Calendar Year Deductibles apply	

Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans					
	DBM Network Facilities	**BCBS PPO In-Network Hospitals**	**BCBS PPO In-Network Free Standing Diagnostic Facilities**	**Non-PPO Out-of-Network Hospitals**	**Non-PPO Out-of-Network Free Standing Diagnostic Facilities**
• Hospital/Facility Fee:					
– Amount Paid by Plan	100%	100%	90%	60%	60%*
– Calendar Year Deductible	None	None	Applies	None	Applies
• Professional Fees (Reading & Interpretation of Films):					
– Amount Paid by Plan	100%	90%	90%	60%	60%*
– PPO/Non-PPO Calendar Year Deductible	None	Applies	Applies	Applies	Applies

	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
Durable Medical Equipment (DME)	90% paid by Plan	60% paid by Plan*
Emergency Room Professional/Physician Fees	90% paid by Plan	90% paid by Plan*
Extended Care/Skilled Nursing Facility	90% paid by Plan	60% paid by Plan*
	Maximum of 120 Days per Convalescent Period	
Hearing Benefit		
• Exam . Per Individual	Paid at 100% up to a $150 Maximum per Individual once every two (2) consecutive Calendar Years Calendar Year Deductible does not apply	
• Hearing Aid Instrument	Paid at 100% up to $2,500 Maximum per Individual once every five (5) consecutive Calendar Years Calendar Year Deductible does not apply	
Home Health Care	90% paid by Plan	60% paid by Plan*
	Maximum of 120 Days per Convalescent Period	
Home Infusion Therapy (HIT)	90% paid by Plan	60% paid by Plan*
Hospice Care	90% paid by Plan	60% paid by Plan*
	Lifetime Maximum of 180 days per Individual	
Infertility Services (Hospital, Physician, Drugs, Treatments, etc.)	90% paid by Plan	60% paid by Plan*
	Lifetime Maximum of $10,000 per Family applies	
Maternity Care	90% paid by Plan	60% paid by Plan*

Organ Transplant (the Fund Office must be called before any treatment is given)			
	BlueCross Blue Distinction Centers for Transplant In-Network Provider	**BCBS In-Network PPO Provider**	**Out-of-Network Non-PPO Provider**
• Hospital/Facility Fee			
– Amount Paid Plan	100%	100%	60%
– Out-of-Pocket Maximum	Does not apply	Does not apply	$3,000 per Admission

Organ Transplant (the Fund Office must be called before any treatment is given) continued			
	BlueCross Blue Distinction Centers for Transplant In-Network Provider	**BCBS In-Network PPO Provider**	**Out-of-Network Non-PPO Provider**
• Physician and Other Professional Providers			
– Amount Paid Plan	100%	90%	60%*
– Calendar Year Deductible	None	Applies	Applies
• Coinsurance	None	Applies	Applies
• Out-of-Pocket Maximum	None	Applies	Applies
• Lifetime Maximum	None	Applies	Applies

	BCBS In-Network PPO Provider	**Out-of-Network Non–PPO Provider**
Physical, Occupational and Speech Outpatient Therapy for Restorative/ Rehabilitative Therapy (to restore an established function)	90% paid by Plan	60% paid by Plan*
Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach) for Dependent Children only, age 18 months and older	90% paid by Plan	60% paid by Plan*
	Maximum of $9,000 per Individual per Calendar Year	
Preventive/Wellness Benefits		
• **Gardasil Vaccine** for Female Dependents Ages 9 to 23	100% paid by Plan	Covered under the $300 Preventative Care Benefit.
	Calendar Year Deductibles do not apply	
• **Preventive Care** including Routine Physical Examinations, Genetic Testing, Adult Immunizations and Reading and Interpretation of a Mammogram	Maximum of $300 per Individual per Calendar Year Calendar Year Deductibles do not apply	
• **Preventive Colorectal Screening for Age 50 or older**		
- Outpatient Hospital Surgi-Center Facility	100% paid by Plan once every 5 consecutive Calendar Years	60% paid by Plan $3,000 Out of Pocket Maximum per Admission applies.
- Outpatient Free Standing Surgi-Center Facility	100% paid by Plan once every 5 consecutive Calendar Years.	NO COVERAGE
- Professional Fees	100% paid by Plan once every 5 consecutive Calendar Years, not subject to Calendar Year Deductible	60%* paid by Plan subject to the $400 per Individual or $1,200 Family Calendar Year Deductible and the $3,000 per Individual or $9,000 Family Calendar Year Out-of-Pocket Maximum
• **Well Child Care Visits and Immunizations for Dependent Children from Birth through Age 6**	100% paid by Plan	Covered under the $300 Preventative Care benefit.
	Calendar Year Deductibles do not apply	
• **Well Child Care Visits and Immunizations for Dependent Children from Ages 7 to 23**	Covered under the $300 Preventative Care benefit.	

	BCBS In-Network PPO Provider	Out-of-Network Non–PPO Provider
Preventive/Wellness Benefits continued		
• **Comprehensive Health Evaluation Program**	100% paid by Plan for all charges associated with a comprehensive health evaluation program through Health Dynamics Care Program. This program is available to all eligible participants and their spouses once every calendar year. The program is not available to dependent children	
Reconstructive Breast Surgery (after a covered Mastectomy)	90% paid by Plan	60% paid by Plan*
Second Surgical Opinion	100% paid by Plan	60% paid by Plan*
Surgical Assistants	90% paid by Plan	60%* paid by Plan, the maximum allowance is 20% of the surgical procedure
Temporomandibular Joint Care (TMJ)		
• Physician Services	90% paid by Plan	60% paid by Plan*
	Subject to $2,000 Lifetime Maximum per Individual	
• Appliances, and their adjustments, for TMJ and Bruxism (Occlusal)	90% paid by Plan, subject to $2,000 Lifetime Maximum per Individual and $400 Individual or $1,200 Family Calendar Year Deductible applies	

*All comprehensive medical and professional benefits are subject to the $2 million lifetime maximum, calendar year deductibles and out. of-pocket maximums. PPO in-network and non-PPO out-of-network deductibles and out-of-pockets maximums are separate and cannot be combined. The Plan does not pay for expenses above reasonable and customary charges for non-PPO out-of-network providers. Amounts over the reasonable and customary allowance are the Covered Individual's responsibility.

MENTAL HEALTH & SUBSTANCE ABUSE CONDITIONS		
	ComPsych In-Network	**Out of Network**
HOSPITAL BENEFITS (Facility Fees)		
In-Patient and/or Partial Hospitalization		
Penalty for failure to Pre-certify	$500 per admission	
Hospital Co-Insurance for In-Patient and Partial Hospitalization	100% paid by Plan	60% Paid by Plan
	Calendar Year Deductible and Comprehensive Medical Lifetime Maximum does not apply	
Hospital Out of Pocket Maximum	$0	$3,000 per admission
Hospital Confinement	180 days per Calendar Year for In-Patient and Partial Hospitalization combined	
Hospital Out Patient Diagnostic Tests	100% paid by Plan	60% paid by Plan
	Calendar Year Deductible and Comprehensive Medical Lifetime Maximum does not apply	
Emergency Room		
Emergency Room Facility Fee	100% paid by Plan	
	Calendar Year Deductible and Comprehensive Medical Lifetime Maximum does not apply	
Emergency Room Co-Payment	$100 per Emergency Room Visit Waived if Immediately Admitted to the Hospital	

COMPREHENSIVE BENEFITS (Professional Fees)*		
	ComPsych In-Network	**Out of Network**
Lifetime Maximum (for Hospital, Comprehensive Medical, Mental Health and Substance Abuse)	$2,000,000 per Individual	
Calendar Year Deductible	$200 per Individual $600 Family Maximum	$400 per Individual $1,200 Family Maximum
	Applies to Mental Health & Substance Abuse Benefits	
Coinsurance for Professional Charges	90% paid by Plan	60% paid by Plan*
Out-of-Pocket Maximums per Calendar Year	$1,000 per Individual $3,000 Family Maximum	$3,000 per Individual $9,000 Family Maximum
	Applies to Mental Health & Substance Abuse Benefits	
Intensive Outpatient and Outpatient Treatments		
Plan Pays	90% paid by Plan	60% paid by Plan*
	Subject to Comprehensive Medical Lifetime Maximum, PPO Calendar Year Deductible and PPO Out of Pocket Maximum	Subject to Comprehensive Medical Lifetime Maximum, Non-PPO Calendar Year Deductible and Non-PPO Out of Pocket Maximum
Emergency Room		
Professional Fees	90% paid by Plan	90% paid by Plan*
	Subject to Comprehensive Medical Lifetime Maximum, PPO Calendar Year Deductible and PPO Out of Pocket Maximum	Subject to Comprehensive Medical Lifetime Maximum, Non-PPO Calendar Year Deductible and Non-PPO Out of Pocket Maximum
Residential, Custodial or Group Homes		
Residential, Custodial or Group Homes **only** for Individuals who Have Suffered from a Traumatic Brain Injury and needs Mental Health or Substance Abuse Treatment	80% of the charged amount, up to a maximum benefit of $650 per day and subject to 120 days per Lifetime Maximum.	No Coverage
	Subject to Comprehensive Medical Lifetime Maximum.	

*All comprehensive medical and professional benefits are subject to the $2 million lifetime maximum, calendar year deductibles and out. of-pocket maximums. PPO in-network and non-PPO out-of-network deductibles and out-of-pockets maximums are separate and cannot be combined. The Plan does not pay for expenses above reasonable and customary charges for non-PPO out-of-network providers. Amounts over the reasonable and customary allowance are the Covered Individual's responsibility.

PRESCRIPTION BENEFIT - MEDCO HEALTH SOLUTIONS			
	Lesser of 100 pills or a 30-day supply at a Medco participating retail pharmacy	Up to a 90-day supply through mail order (Medco by Mail)	For specialty drugs through Accredo, Medco's specialty pharmacy
Generic Co-Payment	$0	$0	n/a
Single-source brand Co-Payment (Generic is not available)	10% $6 minimum $15 maximum	5% $6 minimum $15 maximum	n/a
Multi-source brand Co-Payment (Generic available, but you elect brand name . for any reason)	20% $6 minimum $50 maximum	20% $6 minimum $50 maximum	n/a
Specialty medications (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	n/a	n/a	20% $6 minimum $50 maximum

DENTAL BENEFITS*	
Calendar Year Maximum	$1,500 per Individual
Calendar Year Deductible	$50 per Individual $100 per Family Maximum
Routine Care Benefit includes: • Routine Oral Examination, Diagnostics, Cleaning and Bitewing or Intraoral/Extraoral X-Rays	Two Exams in a 12 month period (to the day) Paid at 100%* $1,500 Calendar Year Maximum applies Calendar Year Deductible does not apply
• Topical Fluoride Application for eligible Dependent children up to 14 years of age	Once in a 12 month period (to the day) Paid at 100%* $1,500 Calendar Year Maximum applies Calendar Year Deductible does not apply
• X-Rays . Complete Mouth Series or Panorex Limited	Once in a 36 month period (to the day) Paid at 100%* $1,500 Calendar Year Maximum applies Calendar Year Deductible does not apply
• X-Rays . Cephalometric	Once in a 24 month period (to the day) Paid at 100%* $1,500 Calendar Year Maximum applies Calendar Year Deductible does not apply
• Emergency Palliative Treatment for Pain and X-Ray (Extraoral or Intraoral)	Paid at 100%* $1,500 Calendar Year Maximum applies Calendar Year Deductible does not apply
General Dental Care includes: • Restorative/Fillings, Gold Restorations, Periodontic and Endodontic Treatment, Oral Surgery, General Anesthesia and Diagnostics	Paid at 80%* $1,500 Calendar Year Maximum applies Calendar Year Deductible applies
• Crowns and Prosthetics, including Dentures, Bridges and Implants	Paid at 80%* $1,500 Calendar Year Maximum applies Calendar Year Deductible applies Replacements once in a (5) five year period (to the day)
Orthodontic Care	Paid at 80%* $2,000 Lifetime Maximum per Individual Calendar Year Deductible does not apply
Appliances, and their adjustments, for: • TMJ and Bruxism (Occlusal) • Snore Guard	Paid at 90%* under the Comprehensive Medical Plan of Benefits subject to the $2,000 Lifetime Maximum per Individual TMJ Benefit and the $400 Individual Calendar Year Deductible applies Paid at 90%* under the Comprehensive Medical Plan of Benefits subject to the $400 Individual Calendar Year Deductible
• Accidental Injury to Teeth	80%* paid by Dental Plan subject to Calendar Year Deductible. If Dental benefit is exhausted, coverage for remainder of repair of teeth will be covered under the Comprehensive Medical benefit payable at 60%* subject to the $400 Individual Calendar Year Deductible and $3,000 Out-of-Pocket Maximum

*The Plan does not pay amounts over the Reasonable and Customary Allowance as adopted by the Fund Office. Amounts over the Reasonable and Customary Allowance are the Covered Individuals responsibility.

VISION BENEFITS		
	EYEMED IN-NETWORK	**OUT-OF-NETWORK**
Eye Exam	100% paid by Plan	$30 per Calendar Year
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 SICKNESS AND ACCIDENT BENEFIT FOR ELIGIBLE PARTICIPANTS ONLY	
Non-Occupational (Not Work-Related)	$300 per week for dates of disability prior to July 1, 2008 and $450 per week for dates of disability on or after July 1, 2008 (Maximum of 52 weeks)

LIFE INSURANCE BENEFIT			
	Eligible Participant	Spouse	Child
Policy Amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR ELIGIBLE PARTICIPANTS ONLY				
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