Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals. These benefits are described in greater detail in the Plan Document.

- The amounts charged for Covered Medical Expenses provided by Network providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R& C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R & C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Deductible)	$6,000 per Covered Individual $18,000 per family
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBS)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 45 visits per Calendar Year Maximum visit limit per spouse: 15 visits per Calendar Year Combined with chiropractic and naprapathy visits No coverage for Dependent children	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
• **Behavioral Health Care**	See page App. A-5	

	BCBS PPO Provider	Out-of-Network Provider
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Deductible does not apply	No coverage
• **Chiropractic Care**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 45 visits per Calendar Year Maximum visit limit per spouse: 15 visits per Calendar Year Combined with acupuncture and naprapathy visits No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
	See Plan Sections 5.04(G)	
• **Contraceptives**, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicide o Vaginal rings o Emergency contraceptives (morning after pill only), generic only o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	80% paid by Plan	60% paid by Plan
	Annual Dental Benefit must be exhausted	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	

<table>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th colspan="2">Out-of-Network Provider</th></tr>
<tr><td>• Genetic Testing Benefit</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>o Genetic testing to the extent required under the Affordable Care Act</td><td colspan="2">100% paid by Plan
Deductible does not apply</td><td colspan="2">60% paid by Plan
Subject to Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500</td></tr>
<tr><td rowspan="2">o Diagnostic genetic testing</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Combined annual maximum benefit of $7,500</td></tr>
<tr><td>o Non-diagnostic genetic testing</td><td colspan="2">No coverage</td><td colspan="2">No coverage</td></tr>
<tr><td>• Hearing Benefit</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>o Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act</td><td colspan="2">100% paid by Plan.
Deductibles does not apply</td><td colspan="2">80% paid by Plan
Deductible does not apply</td></tr>
<tr><td>o Hearing evaluation/exam</td><td colspan="2">Paid at 100% per individual once every two (2) consecutive Calendar Years.
Deductible does not apply</td><td colspan="2">No coverage</td></tr>
<tr><td>o Hearing aid instrument</td><td>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</td><td colspan="2">BCBS PPO Provider</td><td>Out-of-Network Provider</td></tr>
<tr><td>➢ Dependent children through age 18

➢ Participant, spouse and Dependent children age 19 and older</td><td colspan="4">Paid at 100% up to $2,500 maximum per Covered Individual once every three (3) consecutive Calendar Years
Deductible does not apply

Paid at 100% up to $2,500 maximum per Covered Individual once every five (5) consecutive Calendar Years
Deductible does not apply</td></tr>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th colspan="2">Out-of-Network Provider</th></tr>
<tr><td rowspan="2">• Home Health Care</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Maximum of 120 visits per year</td></tr>
<tr><td rowspan="2">• Hospice Care</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Lifetime maximum of 180 days per individual</td></tr>
<tr><td rowspan="2">• Hospital Care</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Confinement maximum: 180 days per Calendar Year for in-patient care</td></tr>
<tr><td rowspan="2">• Infertility Services including Hospital, Physician, prescription drugs & treatments. except diagnostic genetic testing which is covered above</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Combined lifetime maximum of $10,000 for services provided to the Employee and spouse</td></tr>
<tr><td>• Infusion Therapy for the administration of an intravenous prescription drug</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td>• Member Assistance Program</td><td colspan="4">See page App. A-5</td></tr>
<tr><td rowspan="2">• Naprapathy</td><td colspan="2">80% paid by Plan</td><td colspan="2">60% paid by Plan</td></tr>
<tr><td colspan="4">Maximum visit limit per Employee: 45 visits per Calendar Year
Maximum visit limit per spouse: 15 visits per Calendar Year
Combined with acupuncture and chiropractic visits
No coverage for Dependent children</td></tr>
<tr><td>• Nutritional Counseling to the extent required under the Affordable Care Act for chronic disease management</td><td colspan="2">100% paid by Plan
Deductible does not apply</td><td colspan="2">No coverage</td></tr>
</table>

	BCBS PPO Provider	Out-of-Network Provider
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan
• **Organ Transplant**	80% paid by Plan	60% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Restorative/ Rehabilitative Therapy**	80% paid by Plan	60% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Physician Services**	80% paid by Plan	60% paid by Plan
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Deductible does not apply.	60% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis	100% paid by Plan, subject to a $500 lifetime maximum. Not subject to the Calendar Year Deductible	
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan
• **Sterilization** o Females to the extent required under the Affordable Care Act o Males o Sterilization reversals (female/male)	100% paid by Plan. Deductible does not apply 80% paid by Plan No coverage	No coverage No coverage No coverage
• **Substance Use Disorder**	See page App. A-5	
• **Surgi-Center Facility** o Hospital affiliated o No Hospital affiliation	80% paid by Plan 80% paid by Plan	60% paid by Plan No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Wellness and Preventive Care**		
○ **Wellness and Preventive Care** to the extent required under the Affordable Care Act and interpretive guidance, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Deductibles and coinsurance do not apply	No coverage
○ **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Employee and spouse once every Calendar Year. Not available to Dependent children	

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for 5 short-term counseling sessions per issue	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Emergency Room** ○ Facility ○ Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care	
• **Hospital Outpatient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

VISION CARE BENEFITS

Contracted Network Provider: EyeMed Vision Care

	EyeMed In-Network Provider (Participant's Cost)	Out-of-Network Provider (Maximum Amount Plan Pays)
Frequency • Exam • Lenses or contacts • Frame	Once per Calendar Year	
Eye Exam Co-payment (with dilation, if necessary)	$0 Co-pay	Covered Individuals through Age 18: Plan pays 20% Covered Individuals Age 19 and older: Plan pays $30
Exam Options Co-pay: • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to $40 Co-pay 10% off retail	No coverage
Frames Allowance (any available frame at provider location): • Frames up to $200 • Frames over $200	$0 Co-pay 20% off balance over $200	Plan pays $50
Standard Plastic Lenses Co-pay • Single vision • Bifocal • Trifocal • Standard progressive lens • Premium progressive lens o Tier 1 o Tier 2 o Tier 3 o Tier 4	$0 Co-pay $0 Co-pay $0 Co-pay $65 Co-pay $85 Co-pay $95 Co-pay $110 Co-pay $65 Co-pay, 80% of charge of the lenses, less $120 Allowance	Plan Pays $50
Lens Options: • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate – adults • Standard polycarbonate – kids under 19 • Standard anti-reflective coating • Premium anti-reflective coating o Tier 1 o Tier 2 o Tier 3 • Polarized • Photochromic/transaction plastic • Other add-ons	$15 Co-pay $15 Co-pay $15 Co-pay $40 Co-pay $40 Co-pay $45 Co-pay $57 Co-pay $68 Co-pay 80% off charge 20% off retail price $75 Co-pay 20% off retail price	No coverage
Contact Lenses (material only) • Conventional • Disposable • Medically Necessary	Up to $125 = $0 Co-pay. 15% off balance over $125 Up to $125 = $0 Co-pay, plus the balance over $125 $0 Co-pay	Plan pays $75 Plan pays $75 Plan pays $200
Additional Pairs	40% discount off complete pair eye-glass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	**Delta Dental Premier**	**Out-of-Network**
Annual Maximum	$1,500		
Annual Deductible (applies only to Basic and Major Care)	$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. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)**			
o Covered Individual 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, or to the annual maximum
o Covered Individual - age 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)** (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)** (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 (4)**			
o Dependent children through age18	When services are rendered by a Delta Dental provider, the first $4,000 in orthodontia charges are paid at 50%. The remaining charges are paid at 25%. If you met the $2,000 lifetime maximum benefit that was in effect prior to 07-01-2011, all subsequent 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 fee subject to a lifetime maximum of $2,000

(1) **Preventive/Diagnostic Care** includes:	
✓ Oral evaluations (two in 12 month period)	✓ Fluoride Treatment (once in a 12 month period for Dependent children through age 18)
✓ Prophylaxis/Cleaning (two in a 12 month period)	✓ Palliative Treatment
✓ 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)	✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)
(2) **Basic Care includes**:	
✓ Fillings	✓ Endodontics
✓ Oral Surgery	✓ Consultations
✓ General Anesthesia	✓ Removal of cysts & tumors in the mouth
✓ Periodontics	✓ Space Maintainers (5-year interval for Dependent children up to age 13)
(3) **Major Care includes** (services are covered once in a 5 year period) include:	
✓ Crowns, Jackets & Case Restoration	✓ Veneers (Permanent Teeth Only)
✓ Fixed & Removable Bridges	✓ Implants and related services
✓ Partial & Full Dentures	

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

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and Diplomat Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30-day supply)	**ESI By Mail** (Up to a 90-day supply through mail order)	**Diplomat Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum

SHORT TERM DISABILITY BENEFITS (For Employees Only)	
Non-Occupational (Not work-related)	Weekly benefits include a payment up to $450 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit up to 40 hours for a Disability from the date certified by a Physician. Not to exceed 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 EMPLOYEES 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
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500