Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical 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	70% paid by Plan	50% paid by Plan
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	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.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBS)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture**	70% paid by Plan	50% 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**	70% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	70% paid by Plan	50% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	70% paid by Plan	50% 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. C-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**	70% paid by Plan	50% 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	70% paid by Plan	50% 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**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	70% paid by Plan	50% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	70% paid by Plan	50% paid by Plan
• **Durable Medical Equipment**	70% paid by Plan	50% paid by Plan
• **Emergency Room** o Facility o Physician fees	 70% paid by Plan 70% paid by Plan	 70% paid by Plan 70% paid by Plan
• **Emergency Room Co-payment**	$300 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 Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	

	BCBS PPO Provider	Out-of-Network Provider
• **Genetic Testing Benefit** o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Deductible does not apply	50% paid by Plan Subject to Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
• **Hearing Benefit**	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
• **Home Health Care**	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	
• **Hospice Care**	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Individual	
• **Hospital Care**	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for n-patient care	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which is covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Employee and spouse	
• **Infusion Therapy** for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
• **Member Assistance Program**	See page App. C-5	
• **Naprapathy**	70% paid by Plan	50% 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 chiropractic visits No coverage for Dependent children	
• **Nutritional Counseling** to the extent required under the Affordable Care Act for chronic disease management	100% paid by Plan Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	70% paid by Plan	50% paid by Plan
• **Organ Transplant**	70% paid by Plan	50% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Restorative/ Rehabilitative Therapy**	70% paid by Plan	50% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for covered individuals through age 18)	70% paid by Plan	50% paid by Plan
• **Physician Services**	70% paid by Plan	50% paid by Plan
• **Pregnancy Care**	70% 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.	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Prosthetics** o Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis	No coverage	
• **Reconstructive Breast Surgery**	70% paid by Plan	50% 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 70% paid by Plan No Coverage	No Coverage No Coverage No Coverage
• **Substance Use Disorder**	See page App. C-5	
• **Surgi-Center Facility** o Hospital Affiliated o No Hospital Affiliation	70% paid by Plan 70% paid by Plan	50% paid by Plan No coverage
• **Surgical Assistant or Assistant Surgeon**	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	70% paid by Plan	50% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	70% paid by Plan	50% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
• **Wellness and Preventive Care** o **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
o **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 Participant and spouse once every Calendar Year. No coverage for Dependent children	

HEALTH CENTER 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** o Facility o Physician fees	 70% paid by Plan 70% paid by Plan	 70% paid by Plan 70% paid by Plan
• **Emergency Room Co-payment**	$300 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 Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care)	
• **Hospital Outpatient Diagnostic Tests**	70% paid by Plan	50% paid by Plan
• **Outpatient Therapy** (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
• **Custodial or Group Homes**	No coverage	

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	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		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		70% paid by Plan

LIFE INSURANCE BENEFITS Contracted Provider: Self-Funded			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
• Vision Benefits	No coverage
• Dental Benefits	No coverage
• Short Term Disability Benefits	No coverage
• Accidental Death and Dismemberment Insurance Benefits	No coverage