APPENDIX B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree 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 FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per individual $600 per family	$600 per individual
Out-of-Pocket Maximum per calendar year	$2,000 per individual $4,000 per family (includes deductible)	$6,000 per individual
	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	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois

	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
	A Covered Individual is required to contact BCBS before any treatment is given and must be approved for surgery.	

	BCBS PPO Provider	Out-of-Network Provider
• **Breast Feeding Support and Equipment** as 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 Section 5.04(G)	
• **Contraceptives** to the extent required under the Affordable Care Act and interpretive guidance for FDA approved methods for females under age 55: 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, including Office Visits. Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Services for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	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 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	

	BCBS PPO Provider	Out-of-Network Provider
• **Genetic Testing** o Genetic testing to the extent required under the Affordable Care Act o Amniotic fluid or genomic/oncotype testing o Gene expression profiling to determine a treatment plan for a cancer diagnosis	100% paid by Plan 80% paid by Plan 80% paid by Plan	No coverage 60% paid by Plan 60% paid by Plan
• **Hearing Benefit** o Hearing evaluation/exam	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
o Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider** / **Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per individual once every three (3) consecutive Calendar Years. Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $1,500 maximum per individual once every five (5) consecutive Calendar Years. Deductible does not apply	

	BCBS PPO Provider	Out-of-Network Provider
• **Home Health Care**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Hospice Care**	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per individual	
• **Hospital Care**	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care	
• **Infertility Services** (Hospital, Physician, prescription drugs, treatments, etc.)	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse	
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
• **Mental Health Care**	See page B-5	
• **Naprapathy**	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 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**	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 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

	BCBS PPO Provider	Out-of-Network Provider
• **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** • Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
• 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** • Females under age 55 to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
• Males	80% paid by Plan	No coverage
• Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page B-5	
• **Surgi-Center Facility** • Hospital affiliated	80% paid by Plan	60% paid by Plan
• No Hospital affiliation	80% 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) • Physician and therapy services	80% paid by Plan	60% paid by Plan
• 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
• **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	

MENTAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois		
	BCBS 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	
• **Out-Patient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN SECTION. 5.04(T) **Per Benefit Period*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois	
Out-of-Pocket Maximum per Calendar Year	$2,000 per individual / $4,000 per family
Plan Pays	Secondary to Medicare Maximum 180 in-patient days per Calendar Year
• **Medicare Part A Supplement (Hospital Benefit)**	
• First 60 days	Plan pays Medicare Part A Deductible
• 61st through 90th days	Plan pays Medicare Part A Co-payment
• 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
• Additional 365 days	Plan pays 100% of Medicare eligible expenses

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois

Out-of-Pocket Maximum per Calendar Year	$2,000 per individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)***	
• First 60 days	Plan pays Medicare Part A Deductible
• 61st through 90th days	Plan pays Medicare Part A Co-payment
• 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
• Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
• **Medicare Part B Supplement**	
• Medicare Part B Deductible	Not covered by Plan
• Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
• **Blood**	Plan pays for 3 pints
• **Skilled Nursing Facility Care*** - Covered individual must meet Medicare's requirements, including having been in a Hospital for at least 3 days and enter a Medicare approved facility within 30 days of leaving the Hospital	
• First 20 days	Medicare pays all approved amounts
• 21st through 100th day	Plan pays Medicare Part A co-payment
• **At Home Recovery Services** – Home care certified by a Covered Individual's Doctor, for care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
• Benefit for each visit	Plan pays up to $40 per visit
• **Foreign Travel**	
• Calendar Year Deductible	$250 per Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
• Lifetime Maximum for Foreign Travel	$50,000
• **Hearing Benefit**	
• Hearing Aid Instrument	Plan pays 100% up to $1,500 maximum per Individual once every five(5) consecutive Calendar Years
• Hearing Evaluation/Exam	Not covered by Plan

PRESCRIPTION BENEFIT Contracted Network Provider: Express Scripts, Inc. (ESI) and Diplomat Specialty Pharmacy Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.			
	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30-day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Diplomat 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-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	n/a
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	n/a
Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	n/a		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per individual / $3,000 per family		n/a
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per individual / $3,000 per family		n/a
Specialty Medication Out-of-Pocket Maximum per Calendar Year	n/a		$1,500 per individual / $3,000 per family

DENTAL BENEFITS Insurance Carrier: Delta Dental of Illinois			
Eligible Dependents	Spouse and dependent children to age 26		
Annual Deductible (applies to Basic and Major Services only)	$50/Person / $150/Family		
Annual Maximum	$1,500/Person		
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.		
	Delta Dental PPO Network Dentist	**Delta Dental Premier Network Dentist**	**Non-Network Dentist**
Preventive/Diagnostic Services • Oral evaluations (two in a 12 month period) • X-rays (bitewings two in a 12 month period; full mouth or panoramic once in a 36 month period; cephalometric once in a 24 month period) • Prophylaxis/Cleaning (two in a 12 month period) • Fluoride Treatment (once in a 12 month period for dependent children under age 19) • Sealants (1st and 2nd molars only, for dependents under age 15) • Palliative Treatment	**100%***	**100%****	**100%*****
Basic Services • Fillings • Oral Surgery • Periodontics • Endodontics • Removal of cysts & tumors • General Anesthesia (in conjunction with oral surgery) • Consultations • Space Maintainers	**80%***	**80%****	**80%*****
Major Restorative Services • Crowns, Jackets & Case Restoration • Fixed & Removable Bridges • Partial & Full Dentures • Implants and related procedures	**50%***	**50%****	**50%*****
Orthodontia	No coverage		

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's allowed PPO fee. PPO network dentists cannot charge you for costs exceeding the PPO fee.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. Premier dentists may not charge you for costs exceeding the maximum plan allowance.

***Non-network dentists (non-Delta Dental PPO/non-Delta Dental Premier) do not agree to accept Delta Dental's allowed fees as payment in full; payment is based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. These dentists can charge you for costs exceeding the maximum plan allowance.

VISION CARE BENEFITS Insurance Carrier: Delta Dental of Illinois - DeltaVision Insight Network in association with EyeMed Vision Care Network		
	EyeMed In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Paid by Insurance Carrier)**
Frequency • Exam • Lenses or contacts • Frame	Once every 12 months Once every 12 months Once every 24 months	
Eye Exam Co-Payment (with dilation, if necessary)	$10 Co-pay	$35 covered
Contact Lens Fit & Follow-up (available once a comprehensive eye exam has been completed): • Standard contact lens • Premium contact lens	Up to $55 Co-pay for a fit and two follow-up visits 10% off retail price	No coverage
Frames Allowance (any available frame at provider location): • Frames up to $130 • Frames over $130	$0 Co-pay 20% off balance over $130	$65 covered
Standard Plastic Lenses Co-Pay • Single vision • Bifocal • Trifocal	$25 Co-pay $25 Co-pay $25 Co-pay	$25 covered $40 covered $55 covered
Lens Options: • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Standard progressive lens (in addition to Bifocal co-pay) • Premium progressive lens (in addition to Bifocal co-pay) o Tier 1 o Tier 2 o Tier 3 o Tier 4 • 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 $65 Co-pay $85 Co-Pay $95 Co-Pay $110 Co=Pay $65 Co-Pay, 80% off retail, less $120 allowance $45 Co-Pay $57 Co-Pay $68 Co-Pay 80% of charge 80% of charge $65 Co-Pay 20% off retail price	No coverage No coverage No coverage No coverage $40 covered $40 covered No coverage No coverage No coverage No coverage No coverage No coverage No coverage
Contact Lenses (material only) • Conventional o Up to $130 o Amount over $130 • Disposable • Visually Required (as determined by Insurance Carrier for certain medical conditions)	$0 Co-pay. 15% off balance over $130 $0 Co-pay, $130 allowance, plus balance over $130 $0 Co-pay, Covered at 100%	$104 covered $104 covered $200 covered
Additional Pairs	20% Discount on items not covered by the program. 40% discount off complete pair eye-glass purchase. 15% discount off conventional contact lenses once the funded benefit has been used.	No coverage

EXCLUDED BENEFITS	
• Short Term Disability Benefit	No coverage
• Life Insurance Benefits	No coverage
• Accidental Death and Dismemberment Insurance Benefits	No coverage