The table is titled "VISION CARE BENEFITS" and is divided into three columns: Contracted Network Provider: EyeMed Vision Care, EyeMed In-Network Provider (Participant's Cost), and Out-of-Network Provider (Maximum Amount Plan Pays).

Here are the details listed in the table, organized by section:

Frequency

- Exam: Once per Calendar Year
- Lenses or contacts: Once per Calendar Year
- Frames: Once per Calendar Year

Eye Exam Co-payment (with dilation, if necessary)

- EyeMed In-Network Provider: $0 Co-pay
- Out-of-Network Provider:
    - Covered individuals through age 18: Plan pays 20%
    - Covered individuals age 19 and older: Plan pays $30

Exam Options Co-payment

- Standard contact lens fit and follow-up: Up to $40 Co-pay
- Premium contact lens fit and follow-up: 10% off retail
- Out-of-Network Provider: No coverage

Frames Allowance (any available frame at provider location)

- Frames up to $200: $0 Co-pay
- Frames over $200: 20% off balance over $200
- Out-of-Network Provider: Plan pays $50

Standard Plastic or Safety Lenses Co-payment

- Single vision: $0 Co-pay
- Bifocal: $0 Co-pay
- Trifocal: $0 Co-pay
- Standard progressive lens: $65 Co-pay
- Premium progressive lens (Tier 1 to Tier 4): $85 to $110 Co-pay
- Out-of-Network Provider: Plan pays $50
- For premium progressive lenses: $65 co-pay, 80% of charge of the lenses, less $120 Allowance

Lens Options

- UV treatment: $15 Co-pay
- Tint (solid and gradient): $15 Co-pay
- Standard plastic scratch coating: $15 Co-pay
- Standard polycarbonate – adults: $40 Co-pay
- Standard polycarbonate – kids under 19: $40 Co-pay
- Standard anti-reflective coating: $45 Co-pay
- Premium anti-reflective coating (Tier 1 to Tier 3): $57 to $68 Co-pay
- Polarized: 80% off retail price
- Photochromic/transition plastic: $75 co-pay
- Other add-ons: 20% off retail price
- Out-of-Network Provider: No coverage

Contact Lenses (material only)

- Conventional
    - EyeMed In-Network Provider: Up to $125 = $0 Co-pay, 15% off balance over $125
    - Out-of-Network Provider: Plan pays $75
- Disposable
    - EyeMed In-Network Provider: Up to $125 = $0 Co-pay, plus the balance over $125
    - Out-of-Network Provider: Plan pays $75
- Medically necessary
    - EyeMed In-Network Provider: $0 Co-pay
    - Out-of-Network Provider: Plan pays $200

Additional Pairs

- EyeMed In-Network Provider: 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used
- Out-of-Network Provider: No coverage

The table is titled "DENTAL BENEFITS" and it pertains to the coverage provided by Delta Dental of Illinois. Note that dental benefits are not available to an apprentice except as described in the section titled Eligibility, on pages 4-5.

Here are the detailed benefits as listed in the table:

Annual Maximum

- Delta Dental PPO: $1,500
- Delta Dental Premier: $1,500
- Out-of-Network: $1,500

Annual Deductible (applies only to Basic and Major Care)

- Delta Dental PPO: $50/person, $100/family
- Delta Dental Premier: $50/person, $100/family
- Out-of-Network: Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance

Balance Billing (The difference between the Dentist's actual charge and the amount allowed by Delta Dental.)

- Delta Dental PPO: Does not apply
- Delta Dental Premier: Does not apply
- Out-of-Network: Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance

Preventive/Diagnostic Care (1)

- Covered Individual through age 18
    - Delta Dental PPO: Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum
    - Delta Dental Premier: Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
    - Out-of-Network: Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
- Covered Individual – ages 19 and older
    - Delta Dental PPO: Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum
    - Delta Dental Premier: Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum

- Out-of-Network: Paid at 100% of Delta Dental’s maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum

Basic Care (all ages)

- Delta Dental PPO: Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum.
- Delta Dental Premier: Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum.
- Out-of-Network: Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum.

Major Care (all ages)

- Delta Dental PPO: Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum.
- Delta Dental Premier: Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum.
- Out-of-Network: Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum.

Orthodontia

- Dependent children through age 18:
    - Delta Dental PPO: 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 the $2,000 lifetime maximum benefit that was in effect prior to 07-01-2011, all subsequent orthodontia payments will be paid at 25%.
    - Delta Dental Premier: Services are rendered at 50% by a Delta Dental provider for the first $4,000 in orthodontia charges. The remaining charges are paid at 25%. The lifetime maximum benefit is $2,000.
    - Out-of-Network: Paid at 80% of the subject's usual fee dentist to a lifetime maximum of $2,000.
- Adults – ages 19 and older:
    - Delta Dental PPO: Paid at 80% of Delta Dental's PPO reduced fee schedule, subject to a lifetime maximum of $2,000.
    - Delta Dental Premier: Paid at 80% of the dentist's usual fee subject to a lifetime maximum of $2,000.
    - Out-of-Network: Paid at 80% of the dentist's fee subject to the lifetime maximum of $2,000.

The table is titled "PRESCRIPTION BENEFITS" and pertains to the coverage provided by Express Scripts, Inc. and Diplomat Specialty Pharmacy. The table notes that prescription drug benefits are not available to an apprentice except as described in the section titled Eligibility, on pages 4–5.

Here are the detailed benefits as listed in the table:

Out-of-Pocket Maximum per Calendar Year

- $2,000 per Covered Individual
- $4,000 per family

Generic Co-payment

- Express Scripts Retail Pharmacy (Network): $5
- Express Scripts Mail Order (Up to a 90 day supply through mail order): $12.50
- Diplomat Specialty Pharmacy (For specialty drugs): Does not apply

Single-Source Brand Co-payment (A generic is not available)

- Express Scripts Retail Pharmacy (Network): 20% (with a $10 minimum Co-payment per drug with a $100 maximum)
- Express Scripts Mail Order (Up to a 90 day supply through mail order): 20% (with a $25 minimum Co-payment per drug with a $250 maximum)
- Diplomat Specialty Pharmacy (For specialty drugs): Does not apply

Multi-Source Brand Co-payment (A generic is available)

- Express Scripts Retail Pharmacy (Network): 35% (with a $20 minimum Co-payment)
- Express Scripts Mail Order (Up to a 90 day supply through mail order): 35% (with a $50 minimum Co-payment)
- Diplomat Specialty Pharmacy (For specialty drugs): 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)

- Express Scripts Retail Pharmacy (Network): Does not apply
- Express Scripts Mail Order (Up to a 90 day supply through mail order): Does not apply
- Diplomat Specialty Pharmacy (For specialty drugs): 20% (with a $20 minimum Co-payment per drug with a $100 maximum)

The table is titled "SHORT TERM DISABILITY BENEFITS (For Eligible Employees Only)" and provides details about the benefits for non-occupational and occupational disabilities.

Here are the details listed in the table:

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.

The table is titled "LIFE INSURANCE BENEFITS" and outlines the policy amounts provided by Aetna Life Insurance Company. Here are the details:

- **Eligible Participant**: $50,000
- **Spouse**: $2,500
- **Child**: $2,000

The table is titled "ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS" and indicates the benefits provided by Aetna Life Insurance Company for eligible employees. The benefits are outlined as follows:

Type of Loss and **Benefit Amount**:

1. Life: $50,000
2. One hand and one foot: $50,000
3. One foot and sight of one eye: $50,000
4. One hand and sight of one eye: $50,000
5. Sight of both eyes: $50,000
6. Speech and hearing in both ears: $50,000
7. Both feet: $50,000
8. Both hands: $50,000
9. Sight of one eye: $25,000
10. One foot: $25,000
11. One hand: $25,000
12. Thumb and index finger: $12,500