Schedule of Benefits For the Low Cost Medical Plan of Benefits :

The table you've provided is titled "COMPREHENSIVE MEDICAL BENEFITS" and compares the coverage details between a PPO Provider and an Out-of-Network Provider. Here are the details:

- **Coinsurance**
  - PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Deductible per Calendar Year**
  - PPO Provider: $600 per Covered Individual / $1,800 per family
  - Out-of-Network Provider: $600 per Covered Individual / $1,800 per family
- **Out-of-Pocket Maximum per Calendar Year (includes Deductible)**
  - PPO Provider: $4,600 per Covered Individual / $9,200 per family
  - Out-of-Network Provider: $4,600 per Covered Individual / $9,200 per family
- **Additional Note**
  - 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. (This note does not specify whether it applies to both PPO Provider and Out-of-Network Provider, but it is generally inferred to apply to the plan in question.)

The table you've provided is titled "MEDICAL BENEFITS" and indicates the coverage details for various medical services between a BCBS PPO Provider and an Out-of-Network Provider. Below are the details provided in the table:

- **Contracted Network Provider:** BlueCross BlueShield of Illinois (BCBSIL)
- **Ambulance Service**
  - BCBS PPO Provider: 70% paid by Plan subject to the PPO Deductible
  - Out-of-Network Provider: 70% paid by Plan subject to the PPO Deductible
- **Anesthesia or Sedation**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Bariatric Surgery (only for the diagnosis and treatment of morbid obesity)**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
  - Additional Note: 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.
- **Breast-Feeding Support and Equipment to the extent required under the Affordable Care Act**
  - BCBS PPO Provider: 100% paid by Plan, Calendar Year Deductible does not apply
  - Out-of-Network Provider: No coverage
- **Chiropractic Care (Combined Benefit)**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
  - Notes: Maximum visit limit per Employee: 50 visits per Calendar Year. Maximum visit limit per spouse: 30 visits per Calendar Year. No coverage for Dependent children
- **Clinical Trials to the extent required under the Affordable Care Act**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Contraceptives**, including related Office Visits, to the extent required under the Affordable Care Act for FDA-approved methods for females with reproductive capacity:
  - BCBS PPO Provider: 100% paid by the Plan
  - Out-of-Network Provider: No coverage
  - Notes: Contraceptive support and counseling, Diaphragms, sponges, cervical caps, female condoms and spermicide, Vaginal rings, Emergency contraceptives (generic morning-after pill only), Implants

and implantable rods, Oral contraceptives, generic only, Patch, Injectables, IUD

- **Cosmetic Surgery solely to improve appearance**
  - BCBS PPO Provider: No coverage
  - Out-of-Network Provider: No coverage
- **Dental Services for a Non-Occupational Injury to Teeth**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Diagnostic X-Rays and Lab Tests**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Durable Medical Equipment**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan

- **Emergency Room**
  - Facility fee:
    - BCBS PPO Provider: 70% paid by Plan
    - Out-of-Network Provider : 70% paid by Plan
  - Physician fees:
    - BCBS PPO Provider: 70% paid by Plan
    - Out-of-Network Provider : 70% paid by Plan
- **Emergency Room Co-payment**
  - BCBS PPO: $300 per Emergency Room visit; waived if admitted within 72 hours or in observation for more than 24 hours
  - Out-of-Network: Co-payment no longer applicable after the Calendar Year Out-of-Pocket Maximum is met
- **Extended Care/Skilled Nursing Facility**
  - BCBS PPO: 70% paid by Plan, up to 120 days per convalescent period
  - Out-of-Network: 50% paid by Plan, same maximum days
- **Genetic Testing**
  - Genetic testing as required by the Affordable Care Act:
    - BCBS PPO :100% paid by Plan
    - Out-of-Network: 50% paid by Plan (Out-of-Network), not subject to Calendar Year Deductible, Out-of-Pocket

Maximum, or the combined annual maximum benefit of $7,500

- Diagnostic genetic testing:
  - BCBS PPO :70% paid by Plan
  - Out-of-Network: 50% paid by Plan
- Non-diagnostic genetic testing: No coverage for both PPO and Out-of-Network

- **Hearing Benefit**
  - No coverage except as required by the Affordable Care Act under the Wellness and Preventive Care benefit
- **Home Health Care**
  - BCBS PPO: 70% paid by Plan, up to 120 visits per year
  - Out-of-Network: 50% paid by Plan, with the same visit limit
- **Hospice Care**
  - BCBS PPO: 70% paid by Plan, lifetime maximum of 180 days per covered individual
  - Out-of-Network: 50% paid by Plan, with the same lifetime maximum
- **Hospital Care**
  - BCBS PPO: 70% paid by Plan
  - Out-of-Network: 50% paid by Plan, with a confinement maximum of 180 days per calendar year for inpatient care
- **Infertility Services** (including Hospital, Physician, prescription drugs, and treatments, except diagnostic genetic testing)
  - BCBS PPO: 70% paid by Plan
  - Out-of-Network: 50% paid by Plan, with a combined lifetime maximum of $10,000 for services provided to the employee and spouse
- **Infusion Therapy** (for the administration of an intravenous prescription drug)
  - Both BCBS PPO : 70% paid by Plan
  - Out-of-Network: 50% paid by Plan
- **Nutritional Counseling** (to the extent required under the Affordable Care Act)
  - BCBS PPO Provider: 100% paid by Plan, Calendar Year Deductible does not apply
  - Out-of-Network Provider: No coverage

- **Oral and Maxillofacial Surgery**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Organ Transplant**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Physician Services**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Pregnancy Care**
  - BCBS PPO Provider: 70% paid by Plan, except for services covered under the Affordable Care Act which are paid at 100% by the Plan, and the Calendar Year Deductible does not apply
  - Out-of-Network Provider: 50% paid by Plan
- **Prosthetics**
  - Artificial limbs and eyes:
    - BCBS PPO Provider: 70%
    - Out-of-Network Provider :50%
  - Wigs and hairpieces for hair loss as a result of cancer treatment: BCBS PPO Provider has coverage, Out-of-Network Provider does not provide coverage
- **Reconstructive Breast Surgery**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan
- **Sterilization**
  - For females, to the extent required under the Affordable Care Act:
    - BCBS PPO Provider pays 100%
    - Out-of-Network Provider does not provide coverage
  - Males:
    - BCBS PPO Provider : 70%
    - Out-of-Network Provider does not provide coverage
    - sterilization : does not provide coverage
- **Surgi-Center Facility**
  - Hospital affiliated: BCBS PPO Provider pays 70%, Out-of-Network Provider pays 50%
  - No hospital affiliation: BCBS PPO Provider pays 70%, Out-of-Network Provider does not provide coverage

- **Surgical Assistant or Assistant Surgeon**
  - BCBS PPO Provider: 70% paid by Plan
  - Out-of-Network Provider: 50% paid by Plan, but limited to 20% of the surgical procedure's R&C Allowance
- **Surgical Consultations**
  - BCBS PPO Provider: 70%
  - Out-of-Network Provider: 50% paid by Plan.
- **Temporomandibular Joint Care (TMJ)**
  - Physician and therapy services:
    - BCBS PPO Provider: 70% paid by Plan
    - Out-of-Network Provider : 50% paid by Plan
  - Appliances, and their adjustments, for TMJ and bruxism (occlusal): 70% paid by Plan once every three consecutive years, with a maximum of two appliances per lifetime.
- **Therapy Services**
  - Physical and Speech Outpatient Therapy:
    - BCBS PPO Provider :70% paid by Plan
    - Out-of-Network Provider : 50% paid by Plan
    - maximum of 50 visits per Calendar Year; with the same visit limit
    - For additional benefits beyond the 50 visit maximum limit: BCBS PPO Provider : 50% by Plan Out-of-Network Provider : 30% by Plan
  - Occupational Outpatient Therapy:
    - BCBS PPO Provider :70% paid by Plan
    - Out-of-Network Provider : 50% by Plan
    - with a maximum of 50 visits per Calendar Year
    - Additional benefits beyond the limit are BCBS PPO Provider :70% paid by Plan Out-of-Network Provider : 50% by Plan
    -
  - Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities: 70% paid by Plan (PPO); 50% paid by Plan (Out-of-Network)
- **Urgent/Immediate Care Facilities and Retail Clinics**
  - BCBS PPO Provider :70% paid by Plan
  - Out-of-Network Provider : 50% by Plan
-
- **Vision Surgery** (excluding cosmetic or refractive corrections)
  - BCBS PPO Provider :70% paid by Plan
  - Out-of-Network Provider : 50% by Plan

- **Wellness and Preventive Care**
    - Wellness and Preventive Care to the extent required under the Affordable Care Act:
        - 100% paid by Plan (PPO), Calendar Year Deductible
        - no coverage for Out-of-Network
- **Comprehensive Health Evaluation and Physical Exam** (including services like blood tests, cholesterol exams, stress and flexibility testing, and mammogram or prostate screening): Preferred Contracted Provider is Health Dynamics, and it's 100% paid by Plan for participant and spouse (PPO), no coverage for dependent children, and Calendar Year Deductible does not apply. Out-of-Network coverage is not mentioned.

The table is titled "HEALTH CENTER BENEFITS" and specifies the coverage provided for eligible covered individuals only.

- **Health Center Services**
  - 100% paid by Plan
  - Calendar Year Deductible does not apply

The section of the table is titled "MEMBER ASSISTANCE PROGRAM" and it lists the benefits provided by the contracted network provider, which is ComPsych and Guidance Resources®.

- **Member Assistance Program (MAP)**
  - ComPsych In-Network Provider: 100% paid by Plan for five short-term counseling sessions per issue
  - Out-of-Network Provider: No coverage

The table is titled "BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS" with the contracted network provider listed as ComPsych, Guidance Resources®. It outlines the coverage for services provided by In-Network and Out-of-Network Providers.

- **Emergency Room**
  - Facility fees:
    - In-Network: 70% paid by Plan
    - Out-of-Network Providers: 70% paid by Plan
  - Physician fees:
    - In-Network: 70% paid by Plan
    - Out-of-Network Providers: 70% paid by Plan
- **Emergency Room Co-payment**
  - In-Network Provider: $300 per Emergency Room visit. This co-payment is waived if the patient is admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours. Furthermore, the co-payment is not applicable after the individual meets the Calendar Year Out-of-Pocket Maximum.
  - Out-of-Network Provider: $300 per Emergency Room visit. This co-payment is waived if the patient is admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours. Furthermore, the co-payment is not applicable after the individual meets the Calendar Year Out-of-Pocket Maximum.
- **Hospital Care and Residential Treatment Facilities**
  - In-Network Provider: 70% paid by Plan.
  - Out-of-Network Provider: 50% paid by Plan, with a confinement maximum of 180 days per Calendar Year combined for Hospital and Residential Treatment inpatient care.
- **Hospital Outpatient Diagnostic Tests**
  - In-Network Provider: 70% paid by Plan.
  - Out-of-Network Provider: 50% paid by Plan.
- **Outpatient Therapy** (including Partial Hospitalization)
  - In-Network Provider: 70% paid by Plan.
  - Out-of-Network Provider: 50% paid by Plan.
- **Custodial or Group Homes**
  - No coverage is provided for both In-Network and Out-of-Network Providers.

The table is titled "PRESCRIPTION BENEFITS" and it provides information regarding prescription drug coverage with the Contracted Network Provider listed as "Express Scripts, Inc. and Diplomat Specialty Pharmacy".

Here are the details in subpoints:

- **Out-of-Pocket Maximum per Calendar Year**
  - Express Scripts Retail Pharmacy Network: $2,000 per covered individual, $4,000 per family
  - Express Scripts Mail Order Program: $2,000 per covered individual, $4,000 per family
  - Diplomat Specialty Pharmacy: $2,000 per covered individual, $4,000 per family
- **Generic Co-payment**
  - Express Scripts Retail Pharmacy Network: 70% paid by Plan
  - Express Scripts Mail Order Program: 70% paid by Plan
  - Diplomat Specialty Pharmacy: Does not apply
- **Single-Source Brand Co-payment** (When a generic is not available)
  - Express Scripts Retail Pharmacy Network: 70% paid by Plan
  - Express Scripts Mail Order Program: 70% paid by Plan
  - Diplomat Specialty Pharmacy: Does not apply
- **Multi-Source Brand Co-payment** (When a generic is available)
  - Express Scripts Retail Pharmacy Network: 70% paid by Plan
  - Express Scripts Mail Order Program: 70% paid by Plan
  - Diplomat Specialty Pharmacy: Does not apply
- **Specialty Medications Co-payment**
  - Express Scripts Retail Pharmacy Network: Does not apply
  - Express Scripts Mail Order Program: Does not apply
  - Diplomat Specialty Pharmacy: 70% paid by Plan

The table is titled "LIFE INSURANCE BENEFITS" and indicates the policy amounts provided by a Self-Funded contracted provider.

- **Policy Amount**
  - Eligible Participant: $5,000
  - Spouse: $1,000
  - Child: $1,000

The table is titled "EXCLUDED BENEFITS" and it lists certain benefits that are not covered by the plan:

- **Vision Benefits**: No coverage
- **Dental Benefits**: No coverage
- **Short Term Disability Benefits**: No coverage
- **Accidental Death and Dismemberment Insurance Benefits**: No coverage