Schedule of Benefits–For the Active Plan of Benefits :

The table is titled "COMPREHENSIVE MEDICAL BENEFITS" and it outlines the insurance coverage details for PPO Providers and Out-of-Network Providers. Here are the details in subpoints:

Coinsurance:

- PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan

Deductible per Calendar Year:

- PPO Provider: $300 per Covered Individual, $900 per family
- Out-of-Network Provider: $600 per Covered Individual, $1,800 per family

Out-of-Pocket Maximum per Calendar Year:

- PPO Provider: $2,300 per Covered Individual ($6,900 per family including Calendar Year Deductible)
- Out-of-Network Provider: $6,000 per Covered Individual ($18,000 per family including Calendar Year Deductible)

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. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined.

The table is titled "MEDICAL BENEFITS" for the Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL). Below is the information detailed in subpoints:

- **Ambulance Service**:
  - BCBS PPO Provider: 80% paid by Plan subject to the PPO Deductible
  - Out-of-Network Provider: Not specified in this excerpt.
- **Anesthesia or Sedation:**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
- **Bariatric Surgery (only for the diagnosis and treatment of morbid obesity):**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - Additional Note: Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete CompPsych'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
  - Includes lactation support and counseling, breast pump rental up to the purchase price, and initial supplies (tubing and shields). Limited to one non-retail grade breast pump per pregnancy
  - Hospital-grade breast pump must be Medically Necessary
- **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**
  - BCBS PPO Provider: 80% paid by Plan, with a maximum visit limit per Employee of 50 visits per Calendar Year and 30 visits per Calendar Year for Spouse/Dependent children

- Out-of-Network Provider: 60% paid by Plan, no coverage for Dependent children
- **Clinical Trials (to the extent required by the Affordable Care Act)**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% 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 Plan, Calendar Year Deductible does not apply
- Out-of-Network Provider: No coverage
- Includes contraceptive support and counseling, diaphragms, sponges, cervical caps, female condoms and spermicides, vaginal rings, emergency contraceptives, implants and implantable rods, oral contraceptives, patch, injectables, IUD
- **Cosmetic Surgery (solely to improve appearance)**
- BCBS PPO Provider: Not specified in this excerpt
- Out-of-Network Provider: No coverage
- **Dental Services (for a Non-Occupational Injury to teeth)**
- BCBS PPO Provider: 80% paid by Plan, Annual Dental benefit must be exhausted
- Out-of-Network Provider: 60% paid by Plan
- **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Diagnostic X-Rays and Lab Tests**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Durable Medical Equipment**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Emergency Room**
- Facility fee:
- BCBS PPO Provider: 80% paid by Plan • Out-of-Network Provider: 80% paid by Plan

- Physician fees:
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 80% paid by Plan
- **Emergency Room Co-payment**
- BCBS PPO Provider: $250 per Emergency Room visit waived if admitted to the hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours

- Out-of-Network Provider: Co-payment amount not available in this excerpt; however, it mentions that the co-payment is not applicable after the Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum
- **Extended Care/Skilled Nursing Facility**
- BCBS PPO Provider: 80% paid by Plan, maximum of 120 days per convalescent period
- Out-of-Network Provider: 60% paid by Plan
- **Genetic Testing Benefit**
- Genetic testing 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: 60% paid by Plan subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500
- Diagnostic genetic testing:
- BCBS PPO Provider: 80% paid by Plan, subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500
- Out-of-Network Provider: 60% paid by Plan
- Non-diagnostic genetic testing:
- BCBS PPO Provider: No coverage
- Out-of-Network Provider: No coverage
- **Hearing Benefit**
  - Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act:
    - BCBS PPO Provider: 100% paid by Plan, Calendar Year Deductible does not apply
    - Out-of-Network Provider: 80% paid by Plan, Calendar Year Deductible does not apply
  - Hearing evaluation/exam:
    - BCBS PPO Provider: Paid at 100% per Covered Individual once every two consecutive Calendar Years, Calendar Year Deductible does not apply
    - Out-of-Network Provider: No coverage

- Hearing aid instrument:
  - Dependent children through age 18:
    - Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)
      - BCBS PPO Provider: Paid at 100% up to $2,500 maximum per Covered Individual once every three consecutive Calendar Years
      - Out-of-Network Provider: No coverage
  - Participant, spouse, and Dependent children age 19 and older:
    - BCBS PPO Provider: Paid at 100% up to $2,500 maximum per Covered Individual once every five consecutive Calendar Years, Calendar Year Deductible does not apply
    - Out-of-Network Provider: No coverage
- **Home Health Care**
  - BCBS PPO Provider: 80% paid by Plan, maximum of 120 visits per year
  - Out-of-Network Provider: 60% paid by Plan
- **Hospice Care**
  - BCBS PPO Provider: 80% paid by Plan, lifetime maximum of 180 days per Covered Individual
  - Out-of-Network Provider: 60% paid by Plan
- **Hospital Care**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - Additional note: Confinement maximum: 180 days per Calendar Year for inpatient care
- **Infertility Services including Hospital, Physician, prescription drugs and treatments, except diagnostic genetic testing.**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - Additional note: Combined lifetime maximum of $10,000 for services provided to the Employee and spouse
- **Infusion Therapy for the administration of an intravenous prescription drug**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% 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: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
- **Organ Transplant**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - **Physician Services**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - **Pregnancy Care**
  - BCBS PPO Provider: 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 Calendar Year Deductible does not apply
  - Out-of-Network Provider: 60% paid by Plan
  - **Prosthetics**
  - Artificial limbs and eyes
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis
  - BCBS PPO Provider: 100% paid by Plan, subject to a $500 lifetime maximum. Calendar Year Deductible does not apply
  - Out-of-Network Provider: No information given in this excerpt
  - **Reconstructive Breast Surgery**
  - BCBS PPO Provider: 80% paid by Plan
  - Out-of-Network Provider: 60% paid by Plan
  - **Sterilization**
  - Females 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
- Males
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: No coverage
- Sterilization reversals (female/male)
- BCBS PPO Provider: No coverage
- Out-of-Network Provider: No coverage
- **Surgi-Center Facility**
- Hospital affiliated

- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- No hospital affiliation
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: No coverage
- **Surgical Assistant or Assistant Surgeon**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
- **Surgical Consultations**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Temporomandibular Joint Care (TMJ)**
- BCBS PPO Provider:
- Physician and therapy services: 80% paid by Plan
- Appliances, and their adjustments, for TMJ and bruxism (occlusal): 80% paid by Plan once every three consecutive years, maximum of two appliances per lifetime
- Out-of-Network Provider:
- All services: 60% paid by Plan
- **Therapy Services**
- **Physical and Speech Outpatient Therapy**
- BCBS PPO Provider: 80% paid by Plan, with a maximum of 50 visits per Calendar Year
- Out-of-Network Provider: 60% paid by Plan
- For additional benefits beyond the 50 visit maximum limit, see page 58
- **Occupational Outpatient Therapy**
- BCBS PPO Provider: 80% paid by Plan, with a maximum of 50 visits per Calendar Year
- Out-of-Network Provider: 60% paid by Plan
- For additional benefits beyond the 50 visit maximum limit, see page 58
- **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Covered Individuals through age 18)**

- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Urgent/Immediate Care Facilities and Retail Clinics**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Vision Surgery (excluding Cosmetic or refractive corrections)**
- BCBS PPO Provider: 80% paid by Plan
- Out-of-Network Provider: 60% paid by Plan
- **Wellness and Preventive Care**
- BCBS PPO Provider: 100% paid by Plan, Calendar Year Deductible does not apply
- Out-of-Network Provider: No coverage
- Note: To the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (for a list of services, see ~~www.healthcare.gov~~)
- **Comprehensive Health Evaluation and Physical Exam (including glycosylated hemoglobin (A1c), blood pressure and cholesterol analysis, strep analysis, flexible sigmoidoscopy, colorectal screening, mammogram or prostate testing and more)**
- Preferred Contracted Provider: Health Dynamics
- BCBS PPO Provider: 100% paid by Plan for Employee and spouse once every Calendar Year
- Out-of-Network Provider: No coverage
- Note: Calendar Year Deductible does not apply. No coverage for Dependent children.

The table is titled "MEMBER ASSISTANCE PROGRAM" and it details the benefits provided by the Contracted Network Provider: ComPsych, Guidance Resources®. Here's the information in subpoints:

- **M mber 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 "HEALTH CENTER BENEFITS" and it specifies coverage for eligible covered individuals only. Here's the information provided:

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

The table is titled "BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS" and outlines the coverage details provided by the Contracted Network Provider: ComPsych, Guidance Resources®. Here are the details in subpoints:

- **Emergency Room**
  - Facility:
    - In-Network Provider (ComPsych): 80% paid by Plan
    - Out-of-Network Provider: 80% paid by Plan
  - Physician fees:
    - In-Network Provider (ComPsych): 80% paid by Plan
    - Out-of-Network Provider: 80% paid by Plan
- **Emergency Room Co-payment**
  - In-Network Provider (ComPsych): $250 per Emergency Room Visit, waived if admitted to the hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours. The co-payment is no longer applicable after the Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum.
- **Hospital Care and Residential Treatment Facilities**
  - In-Network Provider (ComPsych): 80% paid by Plan, with a confinement maximum of 180 days per Calendar Year combined for hospital and residential treatment inpatient care.
  - Out-of-Network Provider: 60% paid by Plan
- **Hospital Outpatient Diagnostic Tests**

	• In-Network Provider (ComPsych): 80% paid by Plan • Out-of-Network Provider: 60% paid by Plan
• **Outpatient Therapy (including partial hospitalization)**	
	• In-Network Provider (ComPsych): 80% paid by Plan • Out-of-Network Provider: 60% paid by Plan
• **Custodial or Group Homes**	
	• In-Network Provider (ComPsych): No coverage • Out-of-Network Provider: No coverage