Schedule of Benefits for Active Employees and their Spouses and Dependents as of January 1, 2015

The following chart highlights key features of the Health and Welfare Actives Plan benefits as of January 1, 2015. These benefits are described in detail in your Summary Plan Description/Plan Document booklet. All charges for medical expenses are subject to the Allowable Charges as adopted by the Fund.

Medical Benefits	PPO Provider	Non-PPO Provider
Calendar Year Maximum	None	
Wellness Benefits[1] Employee and Spouse Dependent Child	Plan pays 100%, no Deductible, up to: $450 per Employee and per Spouse per year; expenses over $450 are covered subject to the Deductible and Coinsurance $500 per Dependent child; expenses over $500 are covered subject to the Deductible and Coinsurance	
Federally Mandated Department of Transportation (DOT) Certifying or Recertifying Physical Exam/Drug Test[1]	Plan pays a separate (additional) benefit of 100% up to $125 per test if the exam/test is provided by Concentra, the Plan's preferred provider of this service; no deductible	If you do not use a Concentra provider, DOT Exams are covered under the Plan's Wellness Benefits, combined with any other Wellness Benefits and subject to the limits shown above
Calendar Year Deductible (Applies to all covered expenses, unless otherwise noted)	$200 per person; $400 family maximum	$400 per person; $800 family maximum
Calendar Year Out-of-Pocket Maximum (This amount includes the Calendar Year Deductible and Coinsurance)	$3,000 per person; $6,000 family maximum	$4,000 per person; $8,000 family maximum
Coinsurance (Unless otherwise noted)	Plan pays 90% after Deductible	Plan pays 75% after Deductible
Mental Health Treatment Benefits Inpatient Services Outpatient Services	 Plan pays 90%, no Deductible Plan pays 90%, no Deductible	 Plan pays 75% after Deductible Plan pays 75% after Deductible
Substance Abuse Treatment Benefits Inpatient Services Outpatient Services	 Plan pays 90%, no Deductible Plan pays 90%, no Deductible	 Plan pays 75% after Deductible Plan pays 75% after Deductible
Chiropractic Services Calendar Year Maximum	Plan pays 90% after Deductible 50 visits (PPO and non-PPO combined)	Plan pays 75% after Deductible 50 visits (PPO and non-PPO combined)
Assistant Surgeon	Plan pays 90% after Deductible on up to 25% of fees	Plan pays 75% after Deductible on up to 25% of fees
Transplant Benefits[2]	Plan pays 90% after Deductible	Not covered
Ambulance Services	Plan pays 90% after Deductible; subject to PPO Out-of-Pocket Maximum	Plan pays 90% after Deductible; subject to PPO Out-of-Pocket Maximum
Emergency Room	You pay $75 per visit (waived if admitted), then after Deductible Plan pays 90%	You pay $75 per visit (waived if admitted), then after Deductible Plan pays 90%
Speech Therapy for Developmental Delay	Plan pays 90% after Deductible	Plan pays 75% after Deductible
Calendar Year Maximum	$3,000 per Dependent child per year	

Hearing Benefits	PPO Provider	Non-PPO Provider
Hearing Exam, Aids, and Related Expenses Coinsurance	Plan pays 90%, no Deductible	Plan pays 75%, no Deductible
Benefit Maximum (Aggregate)	$2,000 per person once in every five year period	$2,000 per person once in every five year period

[1] Any covered expenses that exceed these benefit maximums may be covered under the Plan's medical benefits and will be subject to the Plan's Calendar Year Deductible and Coinsurance provisions.

[2] In general, transplant benefits are covered the same as other medical benefits, which means they are subject to the Plan's Deductible and Coinsurance provisions. However, to be considered covered expenses under the Plan, you must contact the Fund Office for pre-authorization before any surgical procedures and you must use providers that participate in the BlueCross BlueShield of Illinois PPO network. Transplant expenses that are not pre-authorized will not be covered by the Plan.

Prescription Drug Benefits	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy[3]	For up to a 30-day supply, Plan pays:	For up to a 30-day supply, Plan pays 75%, no Deductible
Generic	80%	
Brand Name[4]	80%	
Mail Order	For up to a 90-day supply, Plan pays:	Not available
Generic	85%	
Brand Name[4]	80%	
Smoking Cessation Medications		
Lifetime Maximum	$200 per person	

Dental Benefits	Coverage
Calendar Year Maximum[5]	$1,500 per person (including orthodontia)
Orthodontic Maximum[6]	$3,000 lifetime maximum per person per 24-month period (paid at $375 per quarter as long as the Participant remains eligible under the Plan); subject to Calendar Year maximum (see page 27 - 29)
Coinsurance	80% of R&C, no Deductible

Vision Benefits	Coverage
Exam – Once per year[7]	Plan pays 100% up to $75 per person
Lenses/Frames – Once per year	In lieu of contact lenses, Plan pays 100% per person up to:
Single Vision	$45 per lens
Bi-Focal	$55 per lens
Tri-Focal	$75 per lens
Lenticular	$95 per lens
Frames	$150 per set
Contacts Lenses – Once per year	In lieu of lenses/frames, Plan pays 100% per person up to:
Single Vision	$110 per lens
Bi-Focal	$120 per lens
Tri-Focal	$140 per lens

Disability & Death Benefits (Employee Only)	Benefit	
Loss of Time Benefit		
Non-Occupational Benefit	$400 per week (Monday through Friday)	
Occupational Benefit	$100 per week (Monday through Friday)	
Maximum Benefit	26 weeks	
Death Benefit	$30,000	
Accidental Death Benefit	$30,000	
Accidental Dismemberment Benefit	*Under Age 70 Benefit*	*Age 70 and Over Benefit*
For loss of both hands, both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye, one foot and sight of one eye, loss of speech and hearing, or quadriplegia:	$30,000	$10,000
For loss of one hand, one foot, sight of one eye, paraplegia, hemiplegia, loss of speech, or loss of hearing in both ears:	$10,000	$5,000
For loss of thumb and index finger of same hand:	$5,000	$2,500

[3] Remember that you save money when you go to a participating pharmacy because you receive your prescriptions at discounted prices. Prescriptions obtained at Wal-Mart and Sam's Club are not covered. Contraceptives, including Ortho Evra, Nuva Ring, implants, topical, and oral, for the Employee and/or Spouse only. However, oral contraceptives are covered for Dependent children if Physician authorization is provided for medical necessity and then only for non-contraceptive purposes. Certain prescription medications are subject to pre-authorization. If you do not obtain pre-authorization when it is required, the prescription medications will not be covered by the Plan. See your Summary Plan Description booklet for additional information.

[4] If you request a brand-name medication when a generic equivalent is available and your prescription does not specify dispense as written (DAW), you pay 20% plus the difference in cost between the brand-name and generic medication.

[5] Dependent children under age 19 are not subject to the Calendar Year Dental Maximum of $1,500 for their dental exam and dental services or for Medically Necessary Orthodontic Benefits.

[6] Dependent children under age 19 are not subject to the Orthodontic Maximum of $3,000 for Medically Necessary Orthodontic Benefits.

[7] Dependent children under age 19 are not subject to the $75 Vision Exam Maximum, but are subject to the one exam per Calendar Year limit.

Only the Board of Trustees has the authority to determine eligibility for, entitlement to, and the amount of Plan benefits, to construe and interpret the terms, and to exercise all the other powers specified in the Health and Welfare Fund Trust Agreement, the Plan, the Plan Documents, and the procedures of the Fund and Plan. The Trustees may, in their sole discretion, modify, amend, or terminate the Plan in any manner or at any time.