

RETIREE PLAN SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS

Benefits for covered individuals per Benefit Period*

MEDICARE-ELIGIBLE

AND ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS

Contracted Network Provider



**BlueCross BlueShield
of Illinois**

For questions or information on claims or coverage,
call Blue Cross Blue Shield at (855) 354-1858

Select services are available at the Carpenters Center
for Health which are covered by the Plan at 100%.
deductibles and Coinsurance do not apply.



4979 Indiana Ave, Suite 312, Lisle, IL • (312) 337-4150

OUT-OF-POCKET MAXIMUM per calendar year	\$2,000 per covered individual \$4,000 per family
MEDICARE PART A SUPPLEMENT Hospital Benefit Maximum 180 in-patient days per calendar year	Secondary to Medicare, Plan pays: <ul style="list-style-type: none"> First 60 days: Medicare Part A deductible Days 61 - 90: Medicare Part A copayment Day 91 & After, while using 60 lifetime reserve days: Medicare Part A copayment Additional 365 days: 100% of Medicare-eligible expenses
MEDICARE PART B SUPPLEMENT	Secondary to Medicare, Plan pays: <ul style="list-style-type: none"> Medicare Part B deductible: 100% Medical Expenses: 20% of Medicare-eligible expenses at the Medicare approved amount, after the Medicare Part B deductible
BLOOD	Plan pays for first three (3) pints
SKILLED NURSING CARE FACILITY Covered individual must meet Medicare's requirements, including having been in a hospital for at least three (3) days and enter a Medicare-approved facility within 30 days of leaving the hospital	First 20 days: Medicare pays all approved amounts Days 21 - 100: Plan pays Medicare Part A copayment
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 Calendar year Maximum: \$1,600
FOREIGN TRAVEL The Plan does <u>not</u> pay for expenses in excess of the R & C allowance for non-PPO out-of-network providers; amounts over the R & C allowance are the responsibility of the covered individual	Plan pays 80% Calendar year deductible: \$250 per covered individual Lifetime maximum for Foreign Travel: \$50,000
HEARING BENEFIT	See Hearing Benefits schedule

*A "benefit period" begins on the first day the covered individual receives services as an inpatient 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.

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HEARING BENEFITS

		BCBSIL PPO In-Network Provider % Amount Paid by Plan	BCBSIL Out-of-Network Provider % Amount Paid by Plan	EPIC Hearing Healthcare* % Amount Paid by Plan
HEARING EVALUATION/EXAM		100% up to \$150 Maximum per covered individual once every two consecutive calendar years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
HEARING AID INSTRUMENT <i>Calendar year deductible does not apply</i>	Retiree, spouse, & dependent children ages 19 and older	100% up to \$5,000 Maximum per covered individual once every five (5) consecutive calendar years		
	Dependent children through age 18	100% up to \$1,500 Maximum per covered individual once every three (3) consecutive calendar years		

***Plan's Preferred Contracted Network Provider for Hearing Aids:**



EPIC

HEARING HEALTHCARE

EPIC Hearing Healthcare

(866) 956-5400

Monday – Friday: 8:00 a.m. to 8:00 p.m.

www.epichearing.com

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PRESCRIPTION BENEFITS

Not available to deferred lathers or to Medicare-eligible individuals with Medicare Part D coverage.

Claims must be submitted to the Plan's Contracted Network Providers



EXPRESS SCRIPTS®

Express Scripts
 (800) 939-2089
 Representatives available 24/7
www.express-scripts.com



Accredo
 (800) 803-2523
 M – F: 7 a.m. to 10 p.m.
 SAT: 7 a.m. to 4 p.m.
www.accredo.com

	EXPRESS SCRIPTS		ACCREDO
	Network Retail Pharmacy Lesser of 100 units or 30-day supply	Mail Order Program or Walgreens Up to a 90-day supply	Specialty Medications For complex conditions (cancer, hemophilia, etc.)
OUT-OF-POCKET MAXIMUM <i>Per calendar year</i> Excludes Select Specialty Medications	For Single-Source Brand: \$1,500 per covered individual \$3,000 per family For Generic/Multi-Source (combined): \$1,500 per covered individual \$3,000 per family		For Non-Select Specialty: \$1,500/covered individual \$3,000/family
GENERIC Copayment per drug	\$5.00	\$12.50	
SINGLE-SOURCE BRAND <i>Generic not available</i> Copayment per drug	20% \$10 minimum \$100 maximum	20% \$25 minimum \$250 maximum	
MULTI-SOURCE BRAND <i>Generic is available</i> Copayment per drug	35% \$20 minimum	35% \$50 minimum	
NON-SELECT SPECIALTY MEDICATIONS Copayment per drug Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care			20% \$20 minimum \$100 maximum
SELECT SPECIALTY MEDICATIONS <i>Must enroll in the SaveOn SP Program through Accredo for this benefit. For a list of covered specialty medications, please visit www.Accredo.com</i>			\$0 Copayment per Drug for members enrolled in the SaveOn SP Program

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Benefits for covered individuals per Benefit Period*

MEDICARE-ELIGIBLE AND ENROLLED IN HOSPITAL BENEFITS ONLY


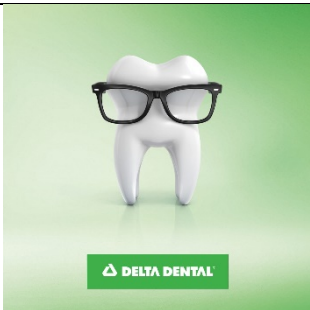

All claims must be submitted to the Plan's Contracted Network Provider



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ADDITIONAL NETWORK PROVIDER OPTIONS

Vision Benefits	Dental Benefits	Life Insurance Benefit
 <p>VSP Vision Care</p> <p>1-800-877-7195 MON – FRI: 7 a.m. to 8 p.m. SAT-SUN: 9 a.m. to 7 p.m.</p>	 <p>Delta Dental of Illinois</p> <p>1-800-323-1743 MON – THU: 7 a.m. to 7 p.m. FRI: 7 a.m. to 6 p.m.</p>	 <p>The Hartford</p> <p>\$25,000 Only Available for Retirees Under Age 65</p>