SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical/Dental/Vision Claim Filing Procedure, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Vision Expense Benefit, Plan Exclusions* and *Preferred Provider or Nonpreferred Provider*.

MEDICAL BENEFITS FOR ACTIVE PARTICIPANTS AND MEDICARE SECONDARY PARTICIPANTS:

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical	$1,000,000	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Chiropractic Care	$1,000	
Skilled Nursing/Extended Care Facility	120 days	
Home Health Care	40 visits	
Wellness Benefit	$1,200	
Deductible Per Calendar Year: (*applies to preferred* and ***nonpreferred providers*)**		
Individual Deductible (Per Person)	$2,000	
Family Deductible	$4,000	
If two or more covered members of a family are injured in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.		
Additional Per Confinement Deductible: (Refer to *Medical Expense Benefit, Deductible*)		
Hospital Admission	$500	
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network***	***Out-of-Network***
Individual (Per Person)	$4,000	$8,000
Family	$8,000	$16,000
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. ***Out-of-Pocket Expense Limits*** **do not contribute toward each other**.		

Coinsurance:
The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance. This 100% provision will not apply to expenses for any participant who has other medical coverage.***

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Inpatient Hospital Additional Deductible Applies.	80%	70%
Preadmission Testing	100%*	100%*
Outpatient Surgery/Ambulatory Surgical Center	80%*	70%*
Emergency Room Services	80%	70%
Primary Care Physician (PCP) Office Visit (General Practitioner, Family Practice, OB/GYN, Internal Medicine and Pediatrician)	$30 Copay then 100%*	70%
Physician's Services (other than PCP Office Visit)	80%	70%
Diagnostic X-rays & Lab Inpatient or Outpatient	80%	70%
Second Surgical Opinion Elective by Covered Person	100%*	100%*
Rehabilitation Facility	80%	70%
Extended Care Facility 50% of the semi-private room rate from which the patient was transferred. Limitation: 120 days ***maximum benefit*** per calendar year	50%	50%
Home Health Care Limitation: 40 visits ***maximum benefit*** per calendar year	80%	70%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling	80%	70%
Smoking Cessation (for office visits to prescribe and monitor smoking cessation medications)	80%	70%
Durable Medical Equipment	80%	70%

* Deductible Waived

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Children's Immunizations Limitation: to age eighteen (18) ***maximum benefit***	100%*	100%*
Wellness Benefit Routine Physical Exams, Pap Smears, Immunizations, Mammograms, and Prostate Exams including office visits and any related laboratory charges. Limitation: $1,200 ***maximum benefit*** per participant per calendar year	100%*	100%*
Routine Colonoscopy Limitation: one (1) routine colonoscopy beginning at age fifty (50) and every five (5) years thereafter or as directed by a physician	80%*	70%*
Mental & Nervous Disorders		
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Chemical Dependency		
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Therapy Services (Physical, Speech, Occupational, etc.)	80%	70%
Birthing Facility	80%	70%
Ambulance Services	80%	70%
Chiropractic Care Limitation: $1,000 ***maximum benefit*** per calendar year	80%	70%
Hearing Aids (please refer to *Medical Expense Benefit*, Hearing Aids) Limitation: $1,400 per ear per 3-year period (this benefit is not subject to copays or deductibles)	80%*	70%*
All Other Covered Expenses	80%	70%

* Deductible Waived

ROUTINE VISION BENEFITS FOR ALL COVERED PARTICIPANTS:

Deductible Per Covered Person Per Calendar Year:	None
Percentage Payable:	100%
Examination Maximum Benefit: Limitation: One (1) exam per person per calendar year.	$40
Corrective Lenses/Frames or Contact Lenses Maximum Benefit: Limitation: Per covered person per calendar year:	$200

Refer to *Vision Expense Benefit* for complete details.

DENTAL BENEFITS FOR ALL COVERED PARTICIPANTS:

Deductible Per Calendar Year:	
Individual	$100
The deductible is waived for diagnostic & preventive dental services.	
Maximum Benefit Per Covered Person For:	
Preventive and Basic services per calendar year	$500
Percentage Payable of Maximum Plan Allowance For:	
Class I - Diagnostic & Preventive Dental Services	100 %
Class II - Basic Dental Services	80 %

Refer to *Dental Expense Benefit* for complete details.

PRESCRIPTION DRUG PROGRAM FOR ALL COVERED PARTICIPANTS:

Retail Deductible Per Calendar Year Per Person:	$100
Retail Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Generic: $10 ***copay*** Preferred Brand Name: $40 ***copay*** Nonpreferred Brand Name: $60 ***copay***
Limitation: 30 day supply	
Mail Order Option	*Deductible does not apply to Mail Order.*
Mail Order Prescription	100% after ***copay***
Copay	Generic: $20 ***copay*** Preferred Brand Name: $80 ***copay*** Nonpreferred Brand Name: $120 ***copay***
Limitation: 90 day supply	

Refer to *Prescription Drug Program* for complete details.

MEDICAL BENEFITS FOR RETIRED PARTICIPANTS:

MEDICAL SCHEDULE OF BENEFITS FOR RETIRED PARTICIPANTS

When Retired Employees or their Dependents become eligible under Medicare, all of the following will happen:

- Medicare pays benefits first.
- All health benefits then in effect for that person stop and are replaced with a new benefit to complement Medicare. The new benefit is a Major Medical Benefit.
- Eligible Charges incurred prior to a person becoming eligible under Medicare in the Calendar Year in which the person becomes eligible under Medicare may be used to satisfy the Cash Deductible under the new Major Medical Benefit for that Calendar Year.
- Payment for any day of confinement or any treatment, services, or supplies given after the date the person becomes eligible under Medicare is made only under the new Major Medical Benefit.
- This new Major Medical Benefit is only for persons eligible under Medicare. It does not apply to any participant unless that participant becomes eligible under Medicare.

The Major Medical Benefit for Retired Employees pays Eligible Charges that are more than the amounts payable for the same expenses under both of the following:

- Medicare Parts A and B.
- Any plan of basic medical benefits sponsored by the Employer for persons eligible under Medicare.

Each participant must satisfy a Cash Deductible of $250 each Calendar Year before any payment is made. The Cash Deductible is the amount of Eligible Charges you must first pay each year for each participant.

If a participant:

- Incurs Eligible Charges during October, November, or December; and
- Uses these Eligible Charges to satisfy the Cash Deductible,

They will also be counted toward that participant's Cash Deductible for the following year.

If two (2) or more family members are hurt in the same accident, only one (1) Cash Deductible will have to be paid for all expenses incurred by the family due to that accident each year.

Then the benefit pays the following percentage of Eligible Charges:

- 50% for Bereavement Counseling.
- 80% of the UCR amount for PPO Providers and 70% of the UCR amount for Non-PPO Providers.

The Eligible Charges payable under this Major Medical Benefit for Retired Employees are the same Eligible Charges payable under Medicare with the exception of Prescription Drug charges.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participation physicians), this Plan determines the amount of Eligible Charges based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physician), this Plan determines the amount of Eligible Charges based on the lesser of the following:

- The Reasonable Charges.
- The amount of the Limiting Charges as defined by Medicare.

OUT-OF-POCKET FEATURE

The Out-of-Pocket Feature does not apply to charges incurred because of cost containment penalties, nor charges incurred due to reduction of UCR nor prescription drug card copays nor Inpatient Hospital Confinement Deductibles. The aforementioned charges will never be paid at 100%, even after the Out-of-Pocket Maximum has been reached.

The amount of Eligible Charges, including the Cash Deductible that you pay, are counted toward the In-Network Out-of-Pocket Maximum or the Out-of-Network Out-of-Pocket Maximum, as applicable. The In-Network Out-of-Pocket Maximum is $2,500 and the Out-of-Network Out-of-Pocket Maximum is $2,500; please note these are separate and do not contribute toward each other. When the Out-of-Pocket Maximum for In-Network is reached for any one person in a Calendar Year, In-Network Eligible Charges, other than those shown above, are payable at 100% for that same person for the rest of that year. When the Out-of-Pocket Maximum for Out-of-Network is reached for any one person in a Calendar Year, Out-of-Network Eligible Charges, other than those shown above, are payable at 100% for that same person for the rest of that year.

MAXIMUM BENEFIT

The Maximum Benefit payable for each participant is $1,000,000. This Maximum applies to each participant's lifetime.

The maximum will include any amount paid under the Employer's Comprehensive Medical Benefit for persons eligible under Medicare in effect prior to the Effective Date.

EXCLUSIONS

The exclusions shown in the "Exclusions" section of this Plan Document also apply to this Major Medical Benefit for Retired Employees and includes ineligible charges under Medicare with the exception of Prescription Drug charges.

SCHEDULE OF BENEFITS FOR MEDICARE PRIMARY PARTICIPANTS:

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical	$1,000,000	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Chiropractic Care	$1,000	
Skilled Nursing/Extended Care Facility	120 days	
Home Health Care	40 visits	
Wellness Benefit	$1,200	
Deductible Per Calendar Year: (*applies to preferred* and *nonpreferred providers*)		
Individual Deductible (Per Person)	$250	
Family Deductible	$500	
If two or more covered members of a family are injured in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.		
Additional Per Confinement Deductible: (Refer to *Medical Expense Benefit, Deductible*)		
Hospital Admission	$200	
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network***	***Out-of-Network***
Individual (Per Person)	$2,500	$2,500
Family	$5,000	$5,000
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. ***Out-of-Pocket Expense Limits*** **do not contribute toward each other**.		

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance. This 100% provision will not apply to expenses for any participant who has other medical coverage.***

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Inpatient Hospital Additional Deductible Applies.	80%	70%
Preadmission Testing	100%*	100%*
Outpatient Surgery/Ambulatory Surgical Center	80%*	70%*
Emergency Room Services	80%	70%
Physician's Services	80%	70%
Diagnostic X-rays & Lab Inpatient or Outpatient	80%	70%
Second Surgical Opinion Elective by Covered Person	100%*	100%*
Rehabilitation Facility	80%	70%
Extended Care Facility 50% of the semi-private room rate from which the patient was transferred. Limitation: 120 days ***maximum benefit*** per calendar year	50%	50%
Home Health Care Limitation: 40 visits ***maximum benefit*** per calendar year	80%	70%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling	80%	70%
Smoking Cessation (for office visits to prescribe and monitor smoking cessation medications)	80%	70%
Durable Medical Equipment	80%	70%

* Deductible Waived

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Children's Immunizations Limitation: to age eighteen (18) ***maximum benefit***	100%*	100%*
Wellness Benefit Routine Physical Exams, Pap Smears, Immunizations, Mammograms, and Prostate Exams including office visits and any related laboratory charges. Limitation: $1,200 ***maximum benefit*** per participant per calendar year	100%*	100%*
Routine Colonoscopy Limitation: one (1) routine colonoscopy beginning at age fifty (50) and every five (5) years thereafter or as directed by a physician	80%*	70%*
Mental & Nervous Disorders		
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Chemical Dependency		
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Therapy Services (Physical, Speech, Occupational, etc.)	80%	70%
Birthing Facility	80%	70%
Ambulance Services	80%	70%
Chiropractic Care Limitation: $1,000 ***maximum benefit*** per calendar year	80%	70%
Hearing Aids (please refer to *Medical Expense Benefit*, Hearing Aids) Limitation: $1,400 per ear per 3-year period (this benefit is not subject to copays or deductibles)	80%*	70%*
All Other Covered Expenses	80%	70%

* Deductible Waived