Section Three
Schedule of Benefits
Effective May 1, 2012

All benefits below are subject to the Plan's terms and conditions, including Deductibles, Copercentages, In Network discounts and Allowable charges. Benefit percentages payable by the Plan may change depending upon whether Covered Services are obtained from an In Network Provider. The list of In Network Providers may change from time to time. You may request a list of In Network Providers at any time. Therefore, it is important to verify that the Provider who is treating you is currently an In Network Provider. See Section Four for more details.

Note: Prenotification is required for all Hospital admissions and some diagnostic procedures, whether Inpatient or Outpatient. See Section Five for more details. The penalty for non-compliance with Prenotification requirements is $250 per occurrence.

Note: The Deductibles and Annual Maximums are combined for both In Network and Out of Network Providers. However, the Out of Pocket Limits are not combined for In Network and Out of Network Providers.

General Provisions

	$400 Deductible Benefit		**$1,000 Deductible Benefit**		**QHDHP Benefit****		**Office Visit Copay Benefit**	
Individual Annual Plan Maximum	**$2,000,000**		**$2,000,000**		**$2,000,000**		**$2,000,000**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Plan Year Deductibles								
Individual	$400	$800	$1,000	$2,000	$2,500	$5,000	$300	$600
Family	$1,200	$2,400	$3,000	$6,000	$5,000	$10,000	$900	$1,800
Benefit Percentage Payable After Satisfaction of the Deductible (unless specified otherwise)	80%	50%	80%	50%	80%	50%	80%	50%
Plan Year Out of Pocket Limits (including Deductible)								
Individual	$1,200	$12,000	$2,000	$12,000	$5,000	$12,000	$2,000	$12,000
Family	$3,600	$36,000	$6,000	$36,000	$10,000	$36,000	$6,000	$36,000

Note: Expenses incurred for the following cannot be applied toward the Out of Pocket Limits: (1) The $250 penalty for failure to Precertify; (2) Any charge excluded in Limitations and Exclusions on Covered Services of this Plan Document; and (3) Copayments.

** **Qualified High Deductible Health Plan** means a "high Deductible health plan" as defined in IRC § 223(c)(2), as may be amended from time to time. Individual deductible limit does not apply to Employee plus One or Employee plus Family coverage.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Allergy Testing and Treatments	80%	50%	80%	50%	80%	50%	80%	50%
Ambulance Service	80% to a maximum $250 per trip		80% to a maximum $250 per trip		80% to a maximum $250 per trip		80% to a maximum $250 per trip	
Convalescent, Extended Care, Rehabilitation and Skilled Nursing Facilities *Maximum Annual Benefit 120 days per Plan Year, unless Prenotified*	80%	50%	80%	50%	80%	50%	80%	50%
Diagnostic Charges and Pre-Admission Testing Lab charges for analysis performed by LabCard paid by Plan at 100%*†	80%	50%	80%	50%	80%	50%	80%	50%
Home Health Care *Maximum Annual Benefit 50 days per Plan Year*	80%	50%	80%	50%	80%	50%	80%	50%
Hospice Care	80%	50%	80%	50%	80%	50%	80%	50%
Hospital Services	80%	50%	80%	50%	80%	50%	80%	50%
Covered Room & Board charge	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate	Semi-private rate
Special Care Unit	80%	50%	80%	50%	80%	50%	80%	50%
Miscellaneous Services	80%	50%	80%	50%	80%	50%	80%	50%
Emergency Room††	80%	50%	80%	50%	80%	50%	80%	50%
Maternity Care *Limit 2 ultrasounds, sonograms, etc.*	80%	50%	80%	50%	80%	50%	80%	50%
Well Newborn Care	80%	50%	80%	50%	80%	50%	80%	50%

* LabCard is a program provided through Quest Diagnostics which offers laboratory services at a reduced cost to the Plan. The Plan does not require a Covered Person to use LabCard's services. However, when a Covered Person chooses to utilize the services of LabCard, by requesting it through his Physician or by using a contracted specimen collection facility, any Deductible is waived and the plan pays 100% of the covered charge.
NOTE: Specimen collection charges are subject to the Plan's normal Deductibles and Co-payments.

† LabCard Select applies to the Qualified High Deductible Health Plan. Benefits are payable on the same basis as any other provider, but charges are deeply discounted.

††Emergency Services rendered by Out of Network Providers will be paid at the In Network level when the services were performed outside the Covered Person's control or election.

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Mental Health Condition								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Occupational/Physical/ Speech Pathology Therapy *Maximum Annual Benefit 60 visits per Plan Year (for each type of therapy) (Treatment plan must be Prenotified)*	80%	50%	80%	50%	80%	50%	80%	50%
Office Visits *(Includes office visits during which routine diagnostic procedures are performed)*[***]								
Designated Primary Care Provider (PCP) and Referred Specialist Office Visits[**] *(This amount also applies to Minor Surgery performed by a PCP during an Office Visit. All other Minor Surgery procedures will be paid as shown elsewhere in the schedule of benefits.)*	85%	50%	85%	50%	90%	50%	100% after $20 Copay[***]	50%
All Other Office Visits	80%	50%	80%	50%	80%	50%	100% after $30 Copay[***]	50%
Outpatient Surgical Services	80%	50%	80%	50%	80%	50%	80%	50%
Physician's Services *(not elsewhere identified in the schedule of benefits)*	80%	50%	80%	50%	80%	50%	80%	50%
Second Surgical Opinion	100%	50%	100%	50%	100%	50%	100%	50%
Non-Surgical Back Treatment *Maximum Annual Benefit 60 visits per Plan Year (Treatment plan must be Prenotified)*	80%	50%	80%	50%	80%	50%	80%	50%
Substance Use Disorder								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%

[**] For a Covered Person's designated In Network Primary Care Provider (PCP) (see Section Four for instructions on designating a PCP with the Plan) or for an In Network Specialist to whom the Covered Person's PCP has notified the Plan of a referral, Office Visit charges under the $400 and $1,000 Deductible Benefit Options are paid without application of any deductible. For the QHDHP benefit option, Office Visit charges are paid at 90% once the deductible has been met.

[***] Office Visit Copayments do not apply to the annual Deductibles or Out of Pocket Maximums

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Preventive Care Benefits								
Note: Not Subject to Deductible. Benefit equals 100% of charge up to specified limits								
Annual Physical Examination (age 5+)	$600 Maximum Benefit	No Benefit	$600 Maximum Benefit	No Benefit	$600 Maximum Benefit	No Benefit	$600 Maximum Benefit	No Benefit
Colonoscopy - $3,000 Maximum Benefit								
Age < 50	None	No Benefit	None	No Benefit	None	No Benefit	None	No Benefit
Age 50+	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit	One test every five Plan Years	No Benefit
Hemocult - $32 per test Maximum Benefit								
	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit
Immunizations								
Children to age 19 subject to Physician recommendation	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
Adults - Age 19 + subject to Physician recommendation	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
Mammography								
Age < 30	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Age 30-39	100% of one baseline mammogram.	No Benefit	100% of one baseline mammogram.	No Benefit	100% of one baseline mammogram.	No Benefit	100% of one baseline mammogram.	No Benefit
Age 40-49	100% of one every other Plan Year.	No Benefit	100% of one every other Plan Year.	No Benefit	100% of one every other Plan Year.	No Benefit	100% of one every other Plan Year.	No Benefit
Age 50+	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit	100% of one per Plan Year	No Benefit

	$400 Deductible Benefit		$1,000 Deductible Benefit		QHDHP Benefit		Office Visit Copay Benefit	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Pap Smear Cytology *One test per Plan Year.*	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
PSA Blood Test - $144 per test Maximum Benefit								
Age <50	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Age 50+	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit	One test per Plan Year	No Benefit
Well Child Care – through age 4	100%	50%	100%	50%	100%	50%	100%	50%
Note: All percentages noted above are subject to Deductibles and Allowable fees, unless otherwise noted. Allowable charges for In Network Providers will conform to the pricing/fee arrangements contracted with them.								
Note: Covered Services obtained from an Out of Network Provider will be covered at In Network percentages and rates if the Covered Person was referred to an Out of Network Provider by the treating In Network Provider, subject to receipt of a letter of Medical Necessity by the referring Physician. Covered Services will also be considered at In Network levels if an accident, Injury or Illness occurs and immediate services are required inside or outside the Network covered area.								
Note*:* Out of Network Providers of ancillary services (assistant surgeons, lab, radiology, anesthesia, Durable Medical Equipment, and Emergency room Physicians) will be paid at the In Network level when rendered at a Network facility, or the services were performed outside the Covered Person's control or election.								

Prescription Drug Card

The Prescription Drug Card benefits under this Plan are provided through Express Scripts Drug Card Network, which is separate and distinct from the medical PPO Network. For more specific details regarding covered and/or excluded Prescription Drugs, see Section Six.

This drug card allows the Covered Persons to receive discounts at In Network pharmacies. Prescription Drug Copayments are payable at the time a prescription is filled.

	$400 Deductible Benefit		**$1,000 Deductible Benefit**		**QHDHP Benefit**		**Office Visit Copay Benefit**	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	Plan Pays	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*	*Plan Pays*
Generic Drugs	$20 Copayment, then 100%	No Benefit	$20 Copayment, then 100%	No Benefit	$20 Copayment after Deductible is met	No Benefit	$20 Copayment, then 100%	No Benefit
Brand-Name Drugs								
Preferred	$35 Copayment, then 100%	No Benefit	$35 Copayment, then 100%	No Benefit	$35 Copayment after Deductible is met	No Benefit	$35 Copayment, then 100%	No Benefit
Non-Preferred	$50 Copayment, then 100%	No Benefit	$50 Copayment, then 100%	No Benefit	$50 Copayment after Deductible is met	No Benefit	$50 Copayment, then 100%	No Benefit
Mail Order	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit	Twice the Copayment for a 90 day supply	No Benefit
Covered drugs not obtained with the Prescription Drug Card will not be reimbursed by the Prescription Drug card or by the Plan. Prescription Drug benefits will be paid in accordance with the provisions of the Prescription Drug card contract.								

Coverage, limitations, and exclusions for Prescription Drugs will be determined through the Prescription Drug Card program elected by the TICUA Benefit Consortium and will not be subject to any limitations and exclusions under the major medical plan. The Prescription Drug Card Program is a separate benefit from the major medical plan.