

**Section Three  
Schedule of Benefits  
Effective May 1, 2014**

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**

	<b>\$400 Deductible Benefit</b>		<b>\$1,000 Deductible Benefit</b>		<b>QHDHP Benefit**</b>		<b>Office Visit Copay Benefit</b>	
	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Plan Year Deductibles</b>								
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
<b>Benefit Percentage Payable After Satisfaction of the Deductible</b> (unless specified otherwise)	80%	50%	80%	50%	80%	50%	80%	50%
<b>Plan Year Out of Pocket Limits</b> (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 and out-of-pocket limit does not apply to Employee plus One or Employee plus Family coverage.

	<b>\$400 Deductible Benefit</b>		<b>\$1,000 Deductible Benefit</b>		<b>QHDHP Benefit</b>		<b>Office Visit Copay Benefit</b>	
	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<b>Allergy Testing and Treatments</b>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Ambulance Service*</b>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Convalescent, Extended Care, Rehabilitation and Skilled Nursing Facilities</b> <i>Maximum Annual Benefit 120 days per Plan Year, unless Prenotified</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Diagnostic Charges and Pre-Admission Testing<sup>1</sup></b> <ul style="list-style-type: none"> <li>• Blood testing</li> <li>• Urine testing</li> <li>• Cytology and Pathology (e.g. pap smears, biopsies)</li> <li>• Cultures (e.g., throat culture)</li> </ul>	100%	50%	100%	50%	100% after Deductible	50%	100%	50%
<b>Home Health Care</b> <i>Maximum Annual Benefit 50 days per Plan Year</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Hospice Care</b>	80%	50%	80%	50%	80%	50%	80%	50%

\* Ambulance Services provided Out of Network will be paid at 80% when the Ambulance Service is provided in connection with an Emergency Medical Condition and the Ambulance Service was provided outside of the Covered Person's control or election.

<sup>1</sup>100% coverage for Diagnostic Charges and Pre-Admission Testing and any Deductible, other than the QHDHP Deductible, will be waived when done at an In-Network lab. Note: Any related specimen collection charges are subject to the Plan's normal Deductibles and Co-payments.

To ensure Diagnostic Charges and Pre-Admission Testing services are paid at 100%, you should do the following:

1. If your doctor is collecting your sample in the office, ask that it be sent to a participating In-Network Lab;
2. If your doctor is sending you to a lab for the testing, contact the Care Coordinators at the number on your Plan ID Card, or visit [www.ticua.org/tbc](http://www.ticua.org/tbc) for a list of In-Network labs, or ask for a Lab requisition form to an In-Network Lab.

80% coverage for Out of Network Diagnostic Charges and Pre-Admission Testing when performed outside the Covered Person's control or election. Please see Section 9, Covered Services, for additional information relating to Diagnostic Charges and Pre-Admission Testing.

	\$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
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<b>Hospital Services</b>	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%
X-rays and Other Outpatient or Miscellaneous Services	80%	50%	80%	50%	80%	50%	80%	50%
Emergency Room (Out of Network is covered at 80% when service is provided in connection with an Emergency Medical Condition, otherwise Out of Network is covered at 50%)	80%	50%	80%	50%	80%	50%	80%	50%
Maternity Care <i>Limit 2 ultrasounds, sonograms, etc.</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Mental Health Condition</b>								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
<b>Outpatient Occupational/Physical/Speech Pathology Therapy</b> <i>Maximum Annual Benefit 60 visits per Plan Year (for each type of therapy) (Treatment plan must be Prenotified)</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Office Visits (Includes office visits during which routine diagnostic procedures are performed)***</b>								
<u>Designated Primary Care Provider (PCP) and Pre-notified Specialist Office Visits**</u> (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% after Deductible	50%	100% after \$20 Copay***	50%
<u>All Other Office Visits</u>	80%	50%	80%	50%	80%	50%	100% after \$30 Copay***	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

	<b>\$400 Deductible Benefit</b>		<b>\$1,000 Deductible Benefit</b>		<b>QHDHP Benefit</b>		<b>Office Visit Copay Benefit</b>	
	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<b>Outpatient Surgical Services</b>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Physician's Services</b> <i>(not elsewhere identified in the schedule of benefits)</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Second Surgical Opinion</b>	100%	50%	100%	50%	100%	50%	100%	50%
<b>Non-Surgical Back Treatment</b> <i>Maximum Annual Benefit 60 visits per Plan Year (Treatment plan must be Prenotified)</i>	80%	50%	80%	50%	80%	50%	80%	50%
<b>Substance Use Disorder</b>								
Inpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
Outpatient Care	80%	50%	80%	50%	80%	50%	80%	50%
<b>Preventive Care Benefits</b>								
<b>Note:</b> Preventive Care Benefits are Not Subject to Deductible. Benefit equals 100% of charge <i>For details of what is covered, see Section 9, Covered Services, Preventive Care/ Wellness Services and at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a></i>								
<b>Annual Physical Examination for Adults</b>	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
<b>Colonoscopy</b>								
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
<b>Hemocult</b>	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
<b>Immunizations All ages</b>	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit

	<b>\$400 Deductible Benefit</b>		<b>\$1,000 Deductible Benefit</b>		<b>QHDHP Benefit</b>		<b>Office Visit Copay Benefit</b>	
	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>	<b>In Network</b>	<b>Out of Network</b>
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<b>Mammography</b>								
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
<b>Pap Smear Cytology</b> <i>One test per Plan Year.</i>	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
<b>PSA Blood Test -</b>								
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
<b>Well Child Visits</b>	100%	50%	100%	50%	100%	50%	100%	50%
<b>Well Woman Visits</b>	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
<b>Note:</b> 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.								
<b>Note:</b> 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.								
<b>Note:</b> 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
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<b>Generic Drugs*</b>	\$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
<b>Brand-Name Drugs**</b>								
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
<b>Mail Order* **</b>	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.**

\*For a Covered Person engaged in the Plan's Chronic Conditions Program the copay for generic medications, when available, prescribed to treat the Participant's Chronic Conditions will be waived.

\*\* For a Covered Person engaged in the Plan's Chronic Conditions Program the copay for brand medications prescribed to treat the Participant's Chronic Conditions will be reduced to 50% of the usual copay shown in the schedule.

. See Section 6 for further information about the enhanced prescription benefit or call a Care Coordinator at 1-877-498-6689.

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.