Section Three
Schedule of Benefits
Effective May 1, 2016

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 non-emergency 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**	
	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: Your Out of Pocket (OOP) Limits under the Plan are less than those allowed under the ACA and the IRS for a Qualified High Deductible Health Plan. The ACA/IRS OOP Limits are the lower of the Out of Pocket Limits as set by the IRS and ACA, which in 2016 are $6,550 for an Individual and $13,100 for a Family. Expenses incurred for the following will not be applied toward the Plan's or the ACA/IRS OOP Limits: (1) Non-Covered Services, as set forth in the Limitations and Exclusions section of this Plan, (2) Premiums and (3) Balance Billing. Additionally, Copayments and Prenotification penalties will not be applied towards the Plan's OOP Limits, but will be applied towards the ACA/IRS OOP Limits.

*Under § 1302(c)(1) of the ACA the Individual OOP limit applies to each Individual, regardless of whether the Individual is enrolled in Individual coverage or Family coverage.

** **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[1]	80%	50%	80%	50%	80%	50%	80%	50%
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%
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%
X-rays and Other Outpatient or Miscellaneous Services	80%	50%	80%	50%	80%	50%	80%	50%
Emergency Room (Out of Network will be paid as if the services were provided In Network when service is provided in connection with an Emergency Medical Condition)	80%	80%/50%	80%	80%/50%	80%	80%/50%	80%	80%/50%
Maternity Care *Limit 2 ultrasounds, sonograms, etc.*	80%	50%	80%	50%	80%	50%	80%	50%

[1] Ambulance Services provided Out of Network will be paid as if the services were provided In Network 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.

	$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*
Laboratory Charges(Non-hospital)[§] • Blood testing • Urine testing • Cytology and Pathology (e.g. Pap smears, biopsies) • Cultures (e.g., throat culture)	100%	50%	100%	50%	100% after Deductible	50%	100%	50%
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%

[§] 100% coverage for Outpatient Laboratory Charges and any Deducible, other than the QHDHP Deductible, will be waived when performed at an In Network lab. This does not apply to lab work performed by a hospital on an inpatient or outpatient basis, which may be covered in accordance with other applicable Plan provisions. Note: Any related specimen collection charges are subject to the Plan's normal Deductibles and Co-payments.

To ensure Outpatient Laboratory Charges 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, visit 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 Outpatient Laboratory Charges 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.

[**] 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.

	$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*
Office Visits *(Includes office visits during which routine diagnostic procedures are performed)*[***]								
Designated Primary Care Provider (PCP) and Pre-notified 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% after Deductible	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%

[***] Office Visit Copayments do not apply to the Deductibles or Plan's Out of Pocket Maximums. Copayments do apply to the ACA/IRS OOP Limits; see Note, pg. 4, for further information concerning Out of Pocket Limits.

	$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: Preventive Care Benefits are Not Subject to Deductible. Benefit equals 100% of charge.								
Coverage for preventive services with a rating of A or B from the U.S. Preventive Task Force; found at http://www.uspreventiveservicesstaksforce.org								
Annual Physical Examination for Adults	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit
Colonoscopy								
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	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 (All ages)	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
Pap Smear Cytology *One test per Plan Year*	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	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*
PSA Blood Test								
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 Visits	100%	50%	100%	50%	100%	50%	100%	50%
Well Woman Visits	100%	No Benefit	100%	No Benefit	100%	No Benefit	100%	No Benefit

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 CVS/caremark 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

Except for covered drugs obtained under the QHDHP, 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.

Note that required Copayments will be applied to the ACA/IRS Out of Pocket Limits, but will not be applied to the Plan's OOP Limits.

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.

Medicare Supplement Benefit

***Note*: The Plan requires that Medicare Eligible Covered Retirees and Retiree's Covered Dependents who enroll in Medicare Part B pay the premium for Part B.**

Services	*Medicare Pays*	*Plan Pays*	*You Pay*
Medicare Part A			
Hospitalization (Semi-private room, general nursing and miscellaneous services and supplies)			
First 60 days	All Medicare approved charges less Part A Deductible	The Part A Deductible	Any remaining charges
61-90th day	All Medicare approved charges less daily Copayment	The daily Copayment	Any remaining charges
91st day and after			
While using 60 lifetime reserve days	All Medicare approved charges less daily Copayment	The daily Copayment	Any remaining charges
Once lifetime reserve days are used: additional 365 days	$0	100% of Medicare eligible expenses	Any remaining charges

Services	*Medicare Pays*	*Plan Pays*	*You Pay*
Medicare Part A			
Skilled Nursing Facility Care (Medicare requires that You have been in a Hospital for at least 3 days and then enter a Medicare-approved Facility within 30 days after leaving the Hospital.)			
First 20 days	All Medicare-approved charges	$0	$0
21st - 100th day	All Medicare approved charges less daily Copayment	The daily Copayment	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as Your Physician certifies You are Terminally Ill and You elect to receive these services	All but very limited Copercentage for Outpatient drugs and Inpatient respite care	$0	Any remaining charges

Services	*Medicare Assumed to Pay*	*Plan Pays*	*You Pay*
Medicare Part B			
Medical Services Physician services Medical Supplies Ambulance Other Covered Services, including Outpatient Hospital	80% of Medicare approved charges less the Medicare Part B Deductible	The 20% Copayment plus the Medicare Part B Deductible.	Any remaining charges
Blood	All Medicare Approved charges less the Deductible (equal to costs for first 3 pints) each Calendar Year	Charges for the first 3 pints of blood	Any remaining charges
Clinical Laboratory Services Blood Tests For Diagnostic Services	100%	$0	$0

Medicare Part A and B			
Home Health Care			
Medicare approved services: Medically Necessary skilled care and supplies	100%	$0	$0
Durable Medical Equipment			
First $100 of Medicare approved amounts	0%	100% (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

Services	*Medicare Pays*	*Plan Pays*	*You Pay*
Foreign Travel Not covered by Medicare Medically Necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each Calendar Year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 Lifetime Maximum