



SCHEDULE OF BENEFITS – TEACHERS FIRST CHOICE (TFC)

High Deductible Health Plan – Option 3

Please refer to the Schedule of Benefits issued to the primary covered person. The member identification number and effective date of coverage are printed on the personalized Schedule of Benefits.

Inpatient admissions require Pre-certification. The telephone number to call for Pre-certification is listed on Your identification card.

Covered Expenses for an assistant surgeon, emergency room Physician, lab, x-ray, or anesthesia rendered by a Non-Network provider at a Network facility will be covered at the Network benefit level. When services that are Covered Expenses are performed by a Non-Network provider outside the Covered Person's control or election such services will be covered at the Network benefit Level.

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT		
Maximum Benefit Amount	Unlimited	
HIGH DEDUCTIBLE HEALTH PLAN SINGLE ENROLLMENT ONLY		
DEDUCTIBLE, PER PLAN YEAR <small>Network and Non-Network Deductibles are independent of each other.</small>		
Per Single Enrollment	\$2,000	\$4,000
COINSURANCE PERCENTAGE PAYABLE		
Percentage payable by the Plan	80%	50%
Percentage payable by the Individual	20%	50%
COINSURANCE OUT-OF-POCKET MAXIMUM, PER PLAN YEAR (Excludes Deductible) <small>Network and Non-Network Coinsurance out-of-pocket maximums are independent of each other.</small>		
Per Single Enrollment	\$1,000	\$2,000
FAMILY HIGH DEDUCTIBLE HEALTH PLAN FAMILY ENROLLMENT ONLY		
DEDUCTIBLE, PER PLAN YEAR <small>Network and Non-Network Deductibles are independent of each other.</small>		
Per Family Unit *	\$4,000	\$8,000
COINSURANCE PERCENTAGE PAYABLE		
Percentage payable by the Plan	80%	50%
Percentage payable by the Individual	20%	50%
COINSURANCE OUT-OF-POCKET MAXIMUM, PER PLAN YEAR (Excludes Deductible) <small>Network and Non-Network Coinsurance out-of-pocket maximums are independent of each other.</small>		
Per Family Unit*	\$2,000	\$4,000

* A Family Unit is comprised of any number of eligible members in Your family. Except for Preventive Care Services, the family must satisfy the Family Unit Deductible before any Covered Expenses are paid by the Plan, and the family must satisfy the Family Unit Coinsurance out-of-pocket maximum before any Covered Expenses are paid by the Plan at 100%.

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MEDICAL BENEFITS		
Physician Services		
Office Visit (Primary Care Physician)	80% after Deductible	50% after Deductible
Specialist Office Visits	80% after Deductible	50% after Deductible
Allergy Testing and Treatments	80% after Deductible	50% after Deductible
Spinal Manipulations/Chiropractic Care o Plan Year maximum limit: 26 visits	80% after Deductible	50% after Deductible
Surgery - Inpatient & Outpatient	80% after Deductible	50% after Deductible
Urgent Care	80% after Deductible	50% after Deductible
Hospital Room & Board (Pre-certification required) o Hospital Room and Board payment rate is the semiprivate room rate o Intensive Care Unit payment rate is the Hospital's ICU rate	80% after Deductible	50% after Deductible
Emergency Room – Medical Emergency	80% after Network Deductible	
Emergency Room – Non-Emergency	80% after Deductible	50% after Deductible
Skilled Nursing Facility (Pre-certification required) o Plan Year maximum limit: 60 days	80% after Deductible	50% after Deductible
Ambulance Service	80% after Network Deductible	
Durable Medical Equipment o Equipment must be Medically Necessary	80% after Deductible	50% after Deductible
Home Health Care o Plan Year maximum limit: 60 visits	80% after Deductible	50% after Deductible
Hospice Care (Inpatient Hospice requires Pre-certification)	80% after Deductible	50% after Deductible
Maternity Benefits	80% after Deductible	50% after Deductible
Member Assistance Program (MAP) o Plan Year maximum limit: 3 visits o Through New Directions www.ndbh.com	Covered 100% by MAP	N/A
Organ Transplants (Pre-certification required) o Covered transplants: ▪ Bone Marrow, Lung, Kidney, Heart, Pancreas & Liver o Donor charges are covered when the recipient is a Covered Person	80% after Deductible	Not covered
Outpatient Diagnostic Tests	80% after Deductible	50% after Deductible
Outpatient Rehabilitation Therapies Cardiac Rehabilitation, Neuropsychological Testing, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitative Services & Speech Therapy	80% after Deductible	50% after Deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care <ul style="list-style-type: none"> ○ Preventive Care includes such services as an annual physical exam, mammogram, Pap smear, PSA screening, colorectal cancer screening, immunizations, and preventive x-ray and lab screenings ○ Limitations may apply due to age and frequency <p>See Your Plan Document for more detailed information about Preventive Care Services.</p>	100% Deductible waived	Not covered
Newborn Nursery Care <ul style="list-style-type: none"> ○ Care while the newborn is Hospital confined after birth, charged to the Plan of the newborn ○ Newborn must be enrolled within 31 days of birth 	80% after Deductible	50% after Deductible
Prosthetic Devices	80% after Deductible	50% after Deductible
Second & Third Surgical Opinions <ul style="list-style-type: none"> ○ A third opinion is covered if the second opinion does not support surgery 	100% after Deductible	50% after Deductible
Sterilizations (Reversals Excluded)	80% after Deductible	50% after Deductible
Mental/Nervous Disorders & Substance Abuse Treatments		
Inpatient (Pre-certification required)	80% after Deductible	50% after Deductible
Partial Day	80% after Deductible	50% after Deductible
Outpatient Office Visits	80% after Deductible	50% after Deductible
All Other Covered Expenses	80% after Deductible	50% after Deductible
OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT		
<p>You must present Your Prescription Drug Card to the MedTrak member Pharmacy at time of purchase in order to receive the highest level of benefits.</p> <p>Prescription Drugs apply to Your Deductible and Coinsurance out of pocket limit.</p>		
Prescription Drugs <ul style="list-style-type: none"> ○ Specialty Drugs require prior authorization 	The Plan Pays 80% after medical Deductible	Reimbursement is at the Network <u>allowable cost</u> for the drug. You may have higher out-of-pocket expenses if you use a Non-Participating Pharmacy

MedTrak 90 Program – The program allows a Covered Person to purchase a 90-day supply of non-specialty prescription drugs at a MedTrak 90 pharmacy. The Prescription may qualify for a discounted cost and help You reduce Your out-of-pocket expense.

Generic Program – If a Generic equivalent is available, then that equivalent is the benefit. If the patient or Physician, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate Copay, the difference in cost between the generic and branded product. The difference in cost (penalty) will not be applied to the Medical Expense Deductible or Coinsurance out-of-pocket maximum. Once the Coinsurance out-of-pocket maximum is met, the Covered Person continues to pay the penalty.

Specialty Drugs are high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order pharmacies.

Prior Authorization is required for all Specialty Drugs. In addition, select medications must be filled through a Preferred Specialty Pharmacy. Contact MedTrak Services at (800) 771-4648 to locate a Specialty Pharmacy through the Plan's Pharmacy Benefit Manager.

Step Therapy Program – Many prescriptions are available in a Generic form. Generic drugs reduce Plan costs and should be tried first before purchasing a Brand Name drug. The Step Therapy Program requires a participant to try a Generic Step One drug prior to obtaining a Step Two drug. Step Therapy drugs involve the following classifications:

Antidepressants	Anti-Arthritics	Nasal Steroids
Proton Pump Inhibitors	Lipid Lowering Agents	Bisphosphonates
Anti-Hypertensives	Sedative Hypnotics	Alpha 1 Blockers
Muscle Relaxants	Triptans	

Examples:

- Patient must try generic Ambien before Ambien CR.
- Patient must try a generic of Zocor, Pravachol or Mevacor before Lipitor.
- Patient must try generic Prilosec, PrilosecOTC, or Generic Protonix before Nexium or Aciphex.

Contact MedTrak Services at (800) 771-4648 if You have questions about the Step Therapy Program.

This Schedule of Benefits and the Midwest Public Risk Plan Document are your contract for coverage. All limitations, exclusions and Plan provisions explained in the Plan Document apply to the benefits described in the Schedule of Benefits. The Plan Administrator and the delegates, where responsibility has been delegated to others, shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Schedule of Benefits and Plan Document.

A qualified High Deductible Health Plan (HDHP) provides comprehensive coverage for high cost medical events. An HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. The minimum deductibles and out-of-pocket expense limits are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future. The HDHP may work in conjunction with a Health Savings Account (HSA).