AMERICAN RED CROSS PPO MM200 PLAN BENEFIT PROFILE

If there is a discrepancy between the Plan Benefit Profile and Plan Document, the Plan Document will be the controlling document in determining the benefit.

In addition, TeamCare will also continue to offer the same benefit plan and HMO networks in So. California, No. California and Denver, CO.

PLAN BENEFIT LIMIT	PLAN DEDUCTIBLE (ANNUAL)	OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	$200 per Individual; $500 per Family	$2,500 per Individual; $5,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$20 co-payment for in-network office visit	For non-emergency medical care, your cost is 10% greater than an in-network.

MEDICAL PLAN BENEFITS

For further information, including a full Summary Plan Description (SPD), visit the Fund's website at MyTeamCare.org or call us at 800-TEAMCARE.

Benefit	Description
TeamCare Wellness – Adult A TeamCare Physician must be used.	♦ All Wellness Benefits are payable at 100% according to the Affordable Care Act. ♦ PPO Office visit does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 80% of semi-private room rate with no maximum day limit; then 100% after Out-of-Pocket Expense Limit is met.
Surgical and Obstetrical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Out-of-Pocket Expense Limit is met.
Ambulance Service Benefit	♦ After Plan Deductible, 80% subject to medical necessity review; then 100% after Out-of-Pocket Expense Limit is met.
Outpatient Accidental Bodily Injury Benefit	♦ After Plan Deductible, 80%; then 100% after Out-of-Pocket Expense Limit is met.
TeamCare Lab Benefit For more information call 1-800-646-7788 or visit **labcard.com**	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% (Plan Deductible does not apply) provided the Physician submits the requisition through Quest Lab Card. If a Physician does not submit specimens through Quest Lab Card, simply visit a Quest Diagnostics collection site. Quest Diagnostics LabCard If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 80%; then 100% after Out-of-Pocket Expense Limit is met.
TeamCare Imaging Benefit For more information call 1-877-674-0674 or visit **usimagingnetwork.com**	♦ The TeamCare Imaging Benefit is a voluntary program that covers only MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through US Imaging. US IMAGING If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 80%; then 100% after Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Out-of-Pocket Expense Limit is met for outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and lab procedures for the treatment of cancer. If treatment is provided in a doctor's office, a $20 TeamCare office visit co-payment is due.
Organ Transplant Benefit and Organ Donor Benefit	♦ Prior to an Organ Transplant, a predetermination of benefits must be submitted through the TeamCare network for review. The Organ Donor Benefit covers charges for medical treatment the donor receives for the donation of an organ.
Chiropractic Benefit	♦ After Plan Deductible, 50% of covered charges to a maximum $500 per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
Psychiatric, Alcoholism and Drug Abuse Treatment – Inpatient	After Plan Deductible, 80% of covered charges; then 100% after Out-of-Pocket Expense Limit is met.
Psychiatric, Alcoholism and Drug Abuse Treatment – Outpatient	♦ $20 co-payment for in-network office visit or if hospital based - 80% of covered charges, then 100% after Out of Pocket Expense Limit is met.

We're here to help. Visit ***MyTeamCare.org or call 800-TEAMCARE****.*

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TEAMCARE Rx PRESCRIPTION DRUG BENEFIT

For more information call 1-888-483-2650 or visit **caremark.com**

RETAIL PHARMACY STORE: Under Retail Pharmacy program, the Participant pays 25% co- payment for short-term prescription fills and non-maintenance medications. By the third fill of the same prescription, long-term maintenance medications must be filled through the CVS Caremark Maintenance Choice / Mail Service Pharmacy or be subject to a 50% co-payment if filled through the Retail Pharmacy Program.

MAINTENANCE CHOICE / MAIL SERVICE PHARMACY: Under the CVS Caremark Mail Service Pharmacy or Maintenance Choice, the Participant pays 20% co-payment. Under Maintenance Choice, Participant can receive a 90- day supply of medication at a local CVS pharmacy store.

The Participant's maximum expense for any prescription is $200 per prescription.

If a generic equivalent is available, the Participant must take the generic or be responsible for the cost difference.

DENTAL BENEFITS

Participants may use any dental provider for services without an out-of-network penalty. However, the Fund does offer a voluntary dental network through TeamCare Dental.

Annual Dental Deductible	None
Annual Dental Maximum	$1,500*
Preventive Services	100%
Diagnostic and Restorative	100%
Crown and Bridge Work	80%
Dentures (Full and Partial)	100%
Orthodontic (Child/Adult Child)	$1,500 Lifetime Maximum

** Annual Maximum does not apply to children under age 19.*

The Fund offers a voluntary network through Humana Dental (Group: TC60018) that provides negotiated discounts and protection from balance billing – stretching the Annual Dental Maximum further. To find a provider, call 1-800-592-3112 or visit: **humanadentalnetwork.com**.

VISION BENEFITS

Participants can use any vision provider for services. However, the Fund does offer a voluntary vision network through the TeamCare Vision program.

The Vision Benefits are payable once every 12 months.

The Fund offers TeamCare Vision - a voluntary vision network offered through EyeMed Vision Care (Advantage Plan):

- $10 Participant co-payment for routine eye exam, and
- $0 Participant co-payment for lenses (or contacts to a maximum $80 retail value), and
- $0 Participant co-payment for frames (to a maximum of $100 retail value).

For a directory of EyeMed providers in the Advantage Plan network, call 1-866-393-3401 or visit **eyemedvisioncare.com**. For non-EyeMed providers, the maximum reimbursement for Vision Benefits is:

Eye Exam	$25.00 **
Frames	$30.00
Lenses	$30.00
Bi-Focal Lenses	$40.00
Tri-Focal Lenses	$50.00
Lenticular Lenses	$60.00
Contacts	$60.00

*** Routine Eye Exam charges from non-EyeMed providers for Covered Dependents under age 19 will be subject to Reasonable and Customary limits and paid at 80%.*

SHORT-TERM DISABILITY BENEFIT

Benefit provides $300 per week for 10 weeks and $350 per week for weeks 11-26.

LIFE INSURANCE BENEFITS

Member Death	$20,000
Accidental Death	$20,000
Spouse Death ***	$2,000
Child/Adult Child Death ***	$750
Total Permanent Disability	$11,000

**** Dependent Life Insurance Benefits are only payable on Covered Dependents.*

ASKMAYO CLINIC

Participants have access to the AskMayo nurse line which provides reliable health information. Experienced registered nurses, who draw on the resources of Mayo Clinic, are available to answer your health-related questions. Health information is only a phone call away – 1-800-700-MAYO (6296).

TEAMCARE FAMILY PROTECTION BENEFIT BENEFIT

In the event of a Participant's death, the TeamCare Family Protection Benefit provides a maximum of five years of free coverage for the Covered Spouse and Dependents provided that during the two year period prior to death, TeamCare providers were used exclusively for all non-emergency care. Please refer to the SPD for further information.

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