

## **SCHEDULE OF BENEFITS**

| <b>Preferred Provider Organization (PPO)<br/>Group Health Plan Medical Benefits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| <b>For You and Your Dependents</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p>Medical benefits provide coverage for care In-Network and Out-of-Network. To receive medical benefits, you and your Dependents may have to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance. Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations, and provisions. See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p>You may be responsible to pay for Excess Charges from Out-of-Network Providers and Facilities if the services do not qualify as Emergency Services, Air Ambulance Services, or if services were not provided at an In-Network Facility. In some cases, you may be responsible for paying Excess Charges only if the Out-of-Network Provider gave you a written notice and secured your consent to pay the Excess Charges.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>Coinsurance</b></p> <p>The term Coinsurance is defined as the percentage of the Allowed Amount that you must pay for Covered Expenses to the Provider and/or Facility. Once you have met any applicable Deductible amount, your percentage will be applied to the Allowed Amount for Covered Expenses to determine your financial responsibility. The Plan's percentage will be applied to the Allowed Amount for Covered Expenses to determine the Benefits provided.</p> <p><b>Copayments/Deductibles</b></p> <p>Copayments are amounts to be paid by you or your Dependent for Covered Expenses. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this Plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.</p> <p><b>This Plan has an Embedded Deductible.</b> This means family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.</p> |
| <p><b>Out of Pocket Expenses</b></p> <p>Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the Plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached, all Covered Expenses, except charges for non-compliance penalties and non-covered services, are payable by the Plan at 100% of the Allowed Amount. The Out-of-Pocket Maximum includes Out-of-Pocket Expenses for both Medical and Prescription services.</p> <p><b>This Plan has an Embedded Out-of-Pocket Maximum.</b> This means family members meet only their individual Out-of-Pocket Maximum and then their claims will be covered at 100% of the Allowed Amount; if the family Out-of-Pocket Maximum has been met prior to their individual Out-of-Pocket Maximum being met, their claims will be paid at 100% of the Allowed Amount.</p> <p>The following Out-of-Network Expenses and charges do not contribute to the Out-of-Pocket Maximum and are not payable by the Plan at 100% of the Allowed Amount when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached.</p> <ul style="list-style-type: none"><li>• Non-Compliance Penalties</li><li>• Provider charges in excess of the Allowed Amount</li></ul>                                                       |

**Accumulation of Plan Deductibles and Out-of-Pocket Maximums**

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). Additionally, all other Plan maximums and service-specific maximums (dollar and occurrence) do not cross-accumulate between In- and Out-of-Network unless otherwise noted.

| BENEFIT HIGHLIGHTS                                                                                                        | IN-NETWORK                       | OUT-OF-NETWORK                   |
|---------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|
| <b>Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>                            | \$5,000<br>\$10,000              | \$10,000<br>\$20,000             |
| <b>Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>                 | \$7,000<br>\$14,000              | \$14,000<br>\$28,000             |
| <b>PROFESSIONAL SERVICES</b>                                                                                              | <b>IN-NETWORK</b>                | <b>OUT-OF-NETWORK</b>            |
| Primary Care Office Visit                                                                                                 | \$25 copayment                   | 50% coinsurance after deductible |
| Specialist Office Visit                                                                                                   | \$75 copayment                   | 50% coinsurance after deductible |
| Virtual Care Visit – Primary Care                                                                                         | \$25 copayment                   | 50% coinsurance after deductible |
| Virtual Care Visit – Specialist                                                                                           | \$75 copayment                   | 50% coinsurance after deductible |
| Virtual Care Visit – Doctor on Demand                                                                                     | No charge                        | Not covered                      |
| Preventive Care<br><i>Additional cost-share may apply to non-preventive services provided during a preventive visit.</i>  | No charge                        | Not covered                      |
| Allergy Services<br>(Injections, Serum, Testing)                                                                          | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Laboratory Services                                                                                                       | \$25 copayment                   | 50% coinsurance after deductible |
| X-rays and Diagnostic Imaging                                                                                             | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Advanced Imaging<br>(MRI, CT & PET scans, etc.)<br><i>Pre-certification is required for certain services.</i>             | 20% coinsurance after deductible | 50% coinsurance after deductible |
| <b>EMERGENCY &amp; URGENT CARE SERVICES</b>                                                                               | <b>IN-NETWORK</b>                | <b>OUT-OF-NETWORK</b>            |
| Emergency Room Facility Fee                                                                                               | \$300 copayment after deductible | See In-Network Benefit           |
| Emergency Room Physician Fee                                                                                              | 20% coinsurance after deductible | See In-Network Benefit           |
| Urgent Care Center                                                                                                        | \$85 copayment                   | 50% coinsurance after deductible |
| Ambulance/Emergency Transport<br>(Air & Ground)<br><i>Pre-certification is required for non-emergency transportation.</i> | 20% coinsurance after deductible | See In-Network Benefit           |
| <b>OUTPATIENT SERVICES</b>                                                                                                | <b>IN-NETWORK</b>                | <b>OUT-OF-NETWORK</b>            |
| Outpatient Hospital Surgery Facility Services<br><i>Pre-certification is required for certain services.</i>               | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Outpatient Physician/Surgeon Services                                                                                     | 20% coinsurance after deductible | 50% coinsurance after deductible |

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| Outpatient Rehabilitation Services<br>(Physical, Occupational & Speech Therapy)<br><i>Pre-certification is required for certain services over 5 visits. Physical, Occupational, and Speech Therapy: 20 visits each.</i> | \$75 copayment                   | 50% coinsurance after deductible |
| Outpatient Habilitation Services<br>(Physical, Occupational & Speech Therapy)<br><i>Pre-certification is required for certain services over 5 visits. Physical, Occupational, and Speech Therapy: 20 visits each.</i>   | \$75 copayment                   | 50% coinsurance after deductible |
| Outpatient Anesthesia Services                                                                                                                                                                                          | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Outpatient Hospice Services                                                                                                                                                                                             | 20% coinsurance after deductible | 50% coinsurance after deductible |
| <b>INPATIENT SERVICES</b>                                                                                                                                                                                               | <b>PARTICIPATING</b>             | <b>NONPARTICIPATING</b>          |
| Inpatient Hospital Facility Services<br><i>Pre-certification is required.</i>                                                                                                                                           | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Inpatient Physician/Surgeon Services                                                                                                                                                                                    | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Skilled Nursing Facility<br><i>Pre-certification is required. Up to 60 days per plan year.</i>                                                                                                                          | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Inpatient Rehabilitation Services<br>(Physical, Occupational & Speech Therapy)<br><i>Up to 40 days per plan year, combined, for inpatient therapies.</i>                                                                | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Inpatient Anesthesia Services                                                                                                                                                                                           | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Inpatient Hospice Services<br><i>Pre-certification is required for certain services.</i>                                                                                                                                | 20% coinsurance after deductible | 50% coinsurance after deductible |
| <b>MATERNITY &amp; NEWBORN CARE</b>                                                                                                                                                                                     | <b>PARTICIPATING</b>             | <b>NONPARTICIPATING</b>          |
| Prenatal & Postnatal Care<br><i>Includes the routine sequence of prenatal care office visits as recommended by the American College of Obstetricians and Gynecologists (ACOG).</i>                                      | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Inpatient Hospital & Birthing Center Facility Fee<br><i>Preauthorization required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section.</i>                 | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Newborn Care                                                                                                                                                                                                            | 20% coinsurance after deductible | 50% coinsurance after deductible |
| <b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b>                                                                                                                                                                     | <b>PARTICIPATING</b>             | <b>NONPARTICIPATING</b>          |
| Acupuncture Services<br><i>Up to 20 visits per plan year.</i>                                                                                                                                                           | \$75 copayment                   | 50% coinsurance after deductible |
| Blood and Administration                                                                                                                                                                                                | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Chemotherapy<br><i>Pre-certification is required.</i>                                                                                                                                                                   | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Chiropractic Care<br><i>Up to 20 visits per plan year.</i>                                                                                                                                                              | \$75 copayment                   | 50% coinsurance after deductible |
| Cochlear Implants<br><i>Pre-certification is required.</i>                                                                                                                                                              | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Diabetic Equipment<br><i>Pre-certification is required for certain services.</i>                                                                                                                                        | 20% coinsurance after deductible | 50% coinsurance after deductible |
| Diabetic Supplies<br><i>Preauthorization may be required for certain services. Limited to a 90-day supply.</i>                                                                                                          | 20% coinsurance after deductible | 50% coinsurance after deductible |

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| Durable Medical Equipment, Prosthetics & Orthotics<br><i>Pre-certification is required.</i>                        | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Hearing Aids                                                                                                       | Not covered                                                                                        | Not covered                                                                                        |
| Home Health Care Services<br><i>Pre-certification is required. Up to 100 visits per plan year.</i>                 | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Infertility Services                                                                                               | Not covered                                                                                        | Not covered                                                                                        |
| Intravenous Therapy<br><i>Pre-certification is required.</i>                                                       | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Miscellaneous Medical Supplies                                                                                     | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Nutritional Counseling                                                                                             | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Pre-Admission Testing                                                                                              | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Pulmonary and Respiratory Therapy                                                                                  | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Radiation Therapy                                                                                                  | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Sleep Study                                                                                                        | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| TMJ (Temporomandibular Joint) Services                                                                             | Not covered                                                                                        | Not covered                                                                                        |
| Transplant<br><i>Pre-certification is required.</i>                                                                | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| All Other Covered Services                                                                                         | Benefits based on place of service and subject to applicable Copay, Coinsurance and/or, Deductible | Benefits based on place of service and subject to applicable Copay, Coinsurance and/or, Deductible |
| <b>MENTAL HEALTH, CHEMICAL DEPENDENCY &amp; SUBSTANCE ABUSE SERVICES</b>                                           | <b>PARTICIPATING</b>                                                                               | <b>NONPARTICIPATING</b>                                                                            |
| Outpatient Office and Visits                                                                                       | \$25 copayment                                                                                     | 50% coinsurance after deductible                                                                   |
| Virtual Care Visits – Physician Visit                                                                              | \$25 copayment                                                                                     | 50% coinsurance after deductible                                                                   |
| Virtual Care Visits – Doctor on Demand<br><i>Telemedicine must be \$0.00 after deductible for qualified HDHPs.</i> | No charge                                                                                          | Not covered                                                                                        |
| Inpatient Care<br><i>Preauthorization required except in the case of an emergency.</i>                             | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Intensive Outpatient Treatment                                                                                     | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| Residential Treatment Center<br><i>Preauthorization may be required for certain services.</i>                      | 20% coinsurance after deductible                                                                   | 50% coinsurance after deductible                                                                   |
| <b>PRESCRIPTION DRUGS</b>                                                                                          | <b>PARTICIPATING</b>                                                                               | <b>NONPARTICIPATING</b>                                                                            |
| Retail Pharmacy (31-Day Supply)<br><i>Preauthorization and/or step therapy may be required.</i>                    |                                                                                                    |                                                                                                    |
| Tier 1 - Generic Drugs                                                                                             | \$20 copayment                                                                                     | Not covered                                                                                        |
| Tier 2 - Preferred Brand Drugs                                                                                     | \$60 copayment                                                                                     | Not covered                                                                                        |
| Tier 3 - Non-Preferred Brand Drugs                                                                                 | \$85 copayment                                                                                     | Not covered                                                                                        |
| Tier 4 - Specialty Drug (31-Day supply)                                                                            | 20% coinsurance after deductible                                                                   | Not covered                                                                                        |

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| Mail Order Pharmacy (90-Day Supply)<br><i>Preauthorization and/or step therapy may be required.</i> |                      |                         |
| Tier 1 - Generic Drugs                                                                              | \$50 copayment       | Not covered             |
| Tier 2 – Preferred Brand Drug                                                                       | \$150 copayment      | Not covered             |
| Tier 3 - Non-Preferred Brand Name Drugs                                                             | \$212.50 copayment   | Not covered             |
| Tier 4 - Specialty Drug (31-Day Supply Only)                                                        | Not covered          | Not covered             |
| <b>DENTAL &amp; VISION CARE (Adult &amp; Child)</b>                                                 | <b>PARTICIPATING</b> | <b>NONPARTICIPATING</b> |
| Adult Dental Services                                                                               | Not covered          | Not covered             |
| Adult Vision Exams                                                                                  | Not covered          | Not covered             |
| Lenses, Frames, and Contact Lenses                                                                  | Not covered          | Not covered             |

**NOTE: All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You may be responsible to pay for charges in excess of Allowed Amounts for Covered Expenses obtained from Out-of-Network Providers and Facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Plan Document and Summary Plan Description for more information.**