SCHEDULE OF BENEFITS

Angle Health Standard Plans
Preferred Provider Organization (PPO)
Group Health Plan Medical Benefits

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.

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.

Coinsurance

Coinsurance is 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.

Copayments/Deductibles

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.

This Plan has an Embedded Deductible. 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.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the Plan such as 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.

This Plan has an Embedded Out-of-Pocket Maximum. 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.

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.

- Non-Compliance Penalties.
- Provider charges in excess of the Allowed Amount.
- Non-Covered services.

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	TIER 1 IN-NETWORK	TIER 2 IN-NETWORK	OUT-OF-NETWORK
Deductible • Individual • Family	 $0 $0	 $3,000 $6,000	 $6,000 $12,000
Out-of-Pocket Maximum • Individual • Family	 $5,000 $10,000	 $5,000 $10,000	 $10,000 $20,000
PROFESSIONAL SERVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Office Visit	No charge	$20 copayment	50% coinsurance after deductible
Specialist Office Visit	No charge	$50 copayment	50% coinsurance after deductible
Virtual Care Visit – Primary Care	No charge	$20 copayment	50% coinsurance after deductible
Virtual Care Visit – Specialist	No charge	$50 copayment	50% coinsurance after deductible
Virtual Care Visit – Doctor on Demand *Virtual Care with Doctor on Demand must be $0 after Deductible for Qualified HDHP's.*	No charge	No charge	Not covered
Preventive Care *Additional cost-sharing may apply to non-preventive services provided during a preventive visit.*	No charge	No charge	Not covered
Allergy Services (Injections, Serum, Testing)	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Laboratory Services	No charge	$20 copayment	50% coinsurance after deductible
X-rays and Diagnostic Imaging	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Advanced Imaging (MRI, CT & PET scans, etc.) *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
EMERGENCY & URGENT CARE SERVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Emergency Room Facility Fee	$500 copayment	$500 copayment	$500 copayment
Emergency Room Physician Fee	20% coinsurance	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Center	$75 copayment	$75 copayment	50% coinsurance after deductible
Ambulance/Emergency Transport (Air and Ground) *Pre-certification is required for certain services.*	20% coinsurance	20% coinsurance after deductible	20% coinsurance after deductible
OUTPATIENT SERVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Hospital Surgery Facility Services *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Physician/Surgeon Services	No charge	20% coinsurance after deductible	50% coinsurance after deductible

Outpatient Rehabilitation Services (Physical, Occupational & Speech Therapy) Limited to 20 visits each per Plan year. *Pre-certification is required for certain services.*	No charge	$50 copayment	50% coinsurance after deductible
Outpatient Habilitation Services (Physical, Occupational & Speech Therapy) Limited to 20 visits each per Plan year. *Pre-certification is required for certain services.*	No charge	$50 copayment	50% coinsurance after deductible
Outpatient Anesthesia Services	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Hospice Services	No charge	20% coinsurance after deductible	50% coinsurance after deductible
INPATIENT SERVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Hospital Facility Services *Pre-certification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Physician/Surgeon Services	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility Limited to 60 days per Plan year. *Pre-certification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Rehabilitation Services (Physical, Occupational & Speech Therapy) *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Anesthesia Services	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospice Services. *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
MATERNITY & NEWBORN CARE	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Prenatal & Postnatal Care *Includes the routine sequence of prenatal care office visits as recommended by the American College of Obstetricians and Gynecologists (ACOG).*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospital & Birthing Center Facility Fee *Preauthorization required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Newborn Care	No charge	20% coinsurance after deductible	50% coinsurance after deductible
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Acupuncture Services Limited to 20 visits per Plan year.	No charge	$50 copayment	50% coinsurance after deductible
Blood and Administration	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Chemotherapy *Pre-certification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care Limited to 20 visits per Plan year.	No charge	$50 copayment	50% coinsurance after deductible
Cochlear Implants *Pre-certification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Diabetic Equipment *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Diabetic Supplies *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment, Prosthetics & Orthotics *Pre-certification is required for certain services.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids	Not covered	Not covered	Not covered

Home Health Care Services Limited to 100 visits per plan year. *Precertification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Infertility Services	Not covered	Not covered	Not covered
Intravenous Therapy *Precertification is required.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Miscellaneous Medical Supplies	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Nutritional Counseling	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Pre-Admission Testing	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Pulmonary and Respiratory Therapy	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Radiation Therapy	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Sleep Study	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Temporomandibular Joint (TMJ) Services	Not covered	Not covered	Not covered
Transplant *Precertification is required.*	No charge	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	Benefits based on place of service and subject to applicable Copay, Coinsurance and/or Deductible
MENTAL HEALTH, CHEMICAL DEPENDENCY & SUBSTANCE ABUSE SERVICES	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits	No charge	$20 copayment	50% coinsurance after deductible
Virtual Care Visits – MH/CD/SA Provider	No charge	$20 copayment	50% coinsurance after deductible
Virtual Care Visit – Doctor on Demand *Virtual Care with Doctor on Demand must be $0 after Deductible for Qualified HDHP's.*	No charge	No charge	Not covered
Inpatient Care *Preauthorization is required except in the case of an emergency.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Intensive Outpatient Treatment	No charge	20% coinsurance after deductible	50% coinsurance after deductible
Residential Treatment Center *Preauthorization is required except in the case of an emergency.*	No charge	20% coinsurance after deductible	50% coinsurance after deductible
PRESCRIPTION DRUGS	**IN-NETWORK**		**OUT-OF-NETWORK**
Retail Pharmacy (31-Day Supply) *Prior authorization and or step therapy may be required.*			
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	20% coinsurance after Tier 2 deductible		Not covered
Mail Order Pharmacy (90-Day Supply) *Prior authorization and or step therapy may be required.*			
Tier 1 – Generic Drugs	$50 copayment		Not covered

Tier 2 – Preferred Brand Drugs	$150 copayment		Not covered
Tier 3 – Non-Preferred Brand Drugs	$212.50 copayment		Not covered
Tier 4 – Specialty Drug (31-Day Supply Only)	Not covered		Not covered
DENTAL & VISION CARE (Adult & Child)	**TIER 1 IN-NETWORK**	**TIER 2 IN-NETWORK**	**OUT-OF-NETWORK**
Dental Services	Not covered	Not covered	Not covered
Vision Exams	Not covered	Not covered	Not covered
Lenses, Frames and Contact Lenses	Not covered	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.