MEDICAL SCHEDULE OF BENEFITS

Benefit Period: July 1 – June 30

<table>
<tr><th>MEDICAL BENEFITS-PPO PLAN</th><th>PREFERRED PROVIDER</th><th>NONPREFERRED PROVIDER</th></tr>
<tr><td colspan="3">Deductible per benefit period</td></tr>
<tr><td>Individual</td><td>$500</td><td>$1,000</td></tr>
<tr><td>Family (embedded)</td><td>$1,500</td><td>$3,000</td></tr>
<tr><td colspan="3">Deductible does share between preferred and nonpreferred</td></tr>
<tr><td colspan="3">Generally, each covered person must pay all of the costs from providers up to the deductible amount before the Plan begins to pay.

Embedded family deductible: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.</td></tr>
<tr><td colspan="3">Out-of-Pocket Expense Limit per benefit period (includes deductible, coinsurance, and copays)</td></tr>
<tr><td>Individual</td><td>$3,500</td><td>$7,000</td></tr>
<tr><td>Family (embedded)</td><td>$10,500</td><td>$21,000</td></tr>
<tr><td colspan="3">Out-of-pocket expense limit does share between preferred and nonpreferred</td></tr>
<tr><td colspan="3">The out-of-pocket expense limit is the most the covered person could pay in a year for covered expenses.

The Plan will pay the designated percentage of covered expenses until the out-of-pocket expense limits are reached, at which time the Plan will pay 100% of the remainder of covered expenses for the rest of the benefit period unless stated otherwise.

Embedded family out-of-pocket expense limit: Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit.

The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%:
• expenses not covered by the Plan
• expenses in excess of amounts covered by the Plan
• expenses in excess of customary and reasonable amount
• expenses incurred as a result of failure to obtain pre-certification</td></tr>
<tr><td>Standard coinsurance paid by the Plan</td><td>80%</td><td>60%</td></tr>
</table>

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	Not covered	Not covered
Allergy Services		
Allergy testing, injections and serum	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Ambulance		
Land	80% after deductible	***Preferred Provider*** benefit applies
Air	80% after deductible	***Preferred Provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	80% after deductible	60% after deductible
Bereavement Counseling	80% after deductible	60% after deductible
Birthing Center	80% after deductible	60% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	60% after deductible
Cardiac Rehabilitation		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Chemotherapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	80% after deductible	60% after deductible
	Maximum: 30 visits per plan year	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	Independent Lab/Freestanding Facility 80% after deductible Physicians Office: See **Office Visit & Other Services**	Independent Lab/Freestanding Facility 60% after deductible Physicians Office: See **Office Visit & Other Services**
Diagnostic Services – Minor		
Laboratory and X-ray services		
Independent Lab/Freestanding Facility	80% after deductible	60% after deductible
Other diagnostic services	80% after deductible	60% after deductible
Dialysis Therapy or Treatment		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Emergency Services – (for an ***emergency***)		
Facility (***copay*** waived if admitted or due to an ***accident***)	80% after deductible and $150 ***copay***	***Preferred Provider*** benefit applies
Physician	80% after deductible	***Preferred Provider*** benefit applies
Emergency Services – (not for an ***emergency***)		
Facility	80% after deductible and $150 ***copay***	***Preferred Provider*** benefit applies
Physician	80% after deductible	***Preferred Provider*** benefit applies
Hearing		
Routine Exam	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered
Cochlear Implants/Bone Anchored Hearing Aids *(Medically Necessary)*	80% after deductible	60% after deductible
Home Health Care		
Home health care visits	80% after deductible	60% after deductible
Home health care supplies & services	80% after deductible	60% after deductible
IV therapy	80% after deductible	60% after deductible
Hospice Care		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Hospital – Inpatient		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Anesthesia, Radiology, Pathology, Lab	80% after deductible	60% after deductible
	Maximum: Inpatient Rehabilitation is limited to 60 days per plan year and is combined with Skilled Nursing.	
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Anesthesia, Radiology, Pathology, Lab	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
	Maximum: $5,000 lifetime	
Infusion Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician (includes outpatient visits for ***mental and nervous disorders*** and ***substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Surgery		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
X-ray, lab, minor diagnostics & advanced imaging *(MRIs, CT & PET scans)*		
Primary care physician	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Other services		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Pre-natal and post-natal care	80% after deductible	60% after deductible
Delivery	80% after deductible	60% after deductible
Private Duty Nursing *(Medically Necessary)*		
Inpatient	Not Covered	Not Covered
Outpatient	80% after deductible	60% after deductible
Prostheses	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Radiation Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Respiratory Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Retail Clinic Visits	$50 ***copay*** deductible waived	60% after deductible
Routine Preventive Care/Wellness Benefits - Routine Office Visits, - Periodic Screening Exams, - Routine Gyn Exam/Pap Smear, - Routine Mammogram - Routine Colonoscopy - Routine Prostate Exam	100% up to maximum combined benefit of $500 per ***covered person*** per plan year, then 80% after deductible	60% after deductible
Routine Well-Child Care	Office Visit: 100% deductible waived Immunizations: $25 ***copay*** deductible waived	60% after deductible
Second Surgical Opinion	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
	Maximum: 60 days per plan year combined with Inpatient Rehabilitation	
Telemedicine		
Primary care physician (includes outpatient visits for ***mental and nervous disorders*** and ***substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Therapy Services *(physical, speech and occupational)*		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
	Maximum: 30 visits combined for physical and occupational therapy per plan year. Speech therapy limited to 30 visits per plan year.	

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Transplants (Organ or Tissue) *(pre-certification required)* • Expenses for services that are payable under the Specific Employer Transplant Program.	Please see the Plan Administrative Guide for the Tethys Specific Employer Transplant Program. Contact Tethys Health Ventures through Gerber Life at 1-888-771-0695 for benefit information, pre-authorization of services, and participation in a Tethys Health Center of Excellence Program.	
Urgent Care Center		
Visit	$30 ***copay*** deductible waived	60% after deductible
All other services	100% deductible waived	60% after deductible
Vision – Routine Services	Not Covered	Not Covered
Weight Loss Services		
Surgical treatment	Not Covered	Not Covered
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy)*	80% after deductible	60% after deductible
	Maximum: Limited to one (1) wig lifetime	
All Other C*overed Expenses*	80% after deductible	60% after deductible

PRE-CERTIFICATION REQUIREMENTS – *Covered expenses incurred* for any of the following services shall be reduced by twenty-five percent (25%) if pre-certification is not obtained.

Pre-certification is required for the following services. Refer to *Claim Filing Procedure, Pre-Service Claim Procedure, Filing a Pre-Service Claim* for more information:

- Acute Care- (Services rendered in the hospital setting not included in any other inpatient pre-cert category)
- Routine and high risk maternity (routine only if inpatient stay exceeds federal requirements)
- Long term acute care
- ***Skilled nursing facility***
- Rehabilitation
- Detox
- IP ***mental and nervous disorders/ substance use disorder hospital***
- IP ***mental and nervous disorders/ substance use disorder*** residential
- Transplants - Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant-related travel and lodging
- Diagnostic radiology-CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms
- ***Durable medical equipment***- Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators
- ***Home Health Care*** (home nursing care) - Registered nurse, licensed practical nurse or aid in the home
- Home infusion therapy - Home infusion therapy for immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management
- ***Outpatient*** procedures (not otherwise categorized) - Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty
- Speech Therapy – Treatment and sevices of speech, language and voice. Can also be performed in the home setting.
- Therapeutic radiology - Brachytherapy, proton beam therapy, radiotherapy.

PRESCRIPTION DRUG PROGRAM
SCHEDULE OF BENEFITS

Benefit Period: July 1 – June 30

PRESCRIPTION DRUG PROGRAM BENEFITS -PPO PLAN	PARTICIPATING PHARMACY	NONPARTICIPATING PHARMACY
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay***.		
Retail Pharmacy (34-day supply)		
Generic	$10 ***copay***	Not Covered
Formulary Brand Name	$30 ***copay***	Not Covered
Non-Formulary Brand Name	$60 ***copay***	Not Covered
Retail Pharmacy (90-day supply)		
Generic	$25 ***copay***	Not Covered
Formulary Brand Name	$75 ***copay***	Not Covered
Non-Formulary Brand Name	$150 ***copay***	Not Covered
Mail Order Pharmacy (90-day supply)		
Generic	$25 ***copay***	Not Covered
Formulary Brand Name	$75 ***copay***	Not Covered
Non-Formulary Brand Name	$150 ***copay***	Not Covered
Specialty Drugs (30 -day supply)	Generic: $10 ***copay*** Formulary Brand Name: $30 ***copay*** Non-Formulary Brand Name: $60 ***copay***	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the entire cost of the prescription. **Specialty Drugs** must be purchased through the specialty pharmacy.		