PARKVIEW MEDICAL CENTER, INC.,

d/b/a PARKCARE PLUS

SCHEDULE OF BENEFITS PLAN 1

Effective Date: January 1, 2021

The following is a summary of the benefits, subject to co-payments, deductibles, coinsurance and limitations, provided to you and any covered dependents. ***Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.*** PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.

Medical Benefit	**In-Network**	***Out-of-Network**
Calendar Year Deductible		
Individual	$500	$1,000
Two Family members	$1,000	$2,000
Three or more Family members	$1,400	$2,800
Coinsurance After Deductible or Co-Payment unless otherwise stated below	15%	35%
Calendar Year Out of Pocket maximum		
Individual	$3,250	$5,750
Family (Two or more Family members)	$5,750	$10,750
	Including any applicable Coinsurance, Deductibles, Co-Payments and Prescription Drug Charges.	
In-Network and Out-of-Network Deductible and Out of Pocket maximums will be considered integrated.		
Physician Services (In office)		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	35%, after Deductible
Co-Payment per visit – Specialist	$50 Co-Pay, 0%, Waive Deductible	35%, after Deductible
Injections	15%, after Deductible	35%, after Deductible
Office Surgery and Related Expenses	15%, after Deductible	35%, after Deductible
Office x-ray	15%, after Deductible	35%, after Deductible
Note: MRIs CT Scans, SPECT and PET Scans not covered in office setting.		35%, after Deductible
Office Laboratory (Approved office laboratory charges only)	No Charge	35%, after Deductible
Allergy Office Visit:		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Co-Payment per visit – Specialist	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Allergy Treatment including testing, injection, serum and supplies	No Charge	Not Covered
Telehealth (Mental Nervous Diagnosis Only)		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Co-Payment per visit – Specialist/ Psychiatrist	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Urgent Care	$60 Co-Pay, 0%, Waive Deductible	$60 Co-Pay, 0%, Waive Deductible for Out-of-Area Emergencies only
Rapid Care	$30 Co-Pay, 0%, Waive Deductible	N/A
Other Miscellaneous Physician Services	15%, after Deductible	35%, after Deductible
Preventive Care		
Grade A & B (Based on U.S. Preventive Services Task Force)	No Charge	Not Covered
All Other Services		
Physician's Office	No Charge	Not Covered
Other Outpatient Facilities	No Charge	
Chiropractic Care/ Osteopathic Manipulation	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	12 Visits	

Plan 1 Schedule of Benefits (Cont'd)

Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.		
Medical Benefit	**In-Network**	***Out-of-Network**
Outpatient Laboratory		
LabCorp (Laboratory Services)	No Charge	Not Covered
Lab services that cannot be performed at LabCorp will be paid at the In-Network level of benefits.		
Outpatient Radiology	15%, after Deductible	35%, after Deductible
CT Scans, SPECT & PET Scans, MRIs	$200 Co-Pay, 15%, Waive Deductible	$200 Co-Pay, 35%
Pre-certification is required for PET Scans.		
Emergency Services		
Emergency Room Facility (Co-Pay waived if Admitted)	$300 Co-Pay, 15%, Waive Deductible	
Emergency Room Physicians	15%, Waive Deductible	
Ambulance Services	No Charge	
Hospital Services		
Inpatient/Outpatient	15%, after Deductible	35%, after Deductible
Hospital Room & Board Limitation	Average Semi-Private, Average Private	
Intensive Care Unit Limitation	Average Intensive Care	
Pre-certification is required for Inpatient Hospital Stays.		
Pre-Admission Testing	15%, after Deductible	35%, after Deductible
Inpatient and Outpatient charges for emergency room, radiology, anesthesiology, hospitalist and pathology services rendered by an Out-of-Network Physician will be paid the same as Covered Expenses for an In-Network Physician if such services are performed at an In-Network facility.		
Outpatient Rehabilitation/ Speech Therapy/ Physical Therapy/ Occupational Therapy	15%, after Deductible	Not Covered
Calendar Year Maximum	18 Visits	
BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY PER OCCURRENCE (DEFINED AS PER EPISODE, INJURY OR CONDITION). ADDITIONAL DAYS REQUIRED BEYOND THE MAXIMUM FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY WILL REQUIRE PRIOR AUTHORIZATION.		
Chemotherapy/ Radiation Therapy	15%, after Deductible	35%, after Deductible
Dialysis	15%, after Deductible	35%, after Deductible
Extended Care Services		
Home Health Care	15%, after Deductible	Not Covered
Skilled Nursing Facility	15%, after Deductible	35%, after Deductible
Calendar Year Maximum	45 Days	
Hospice Services	No Charge	Not Covered
Pregnancy		
All Maternity Physician charges (Delivery by PCP or OB/GYN)	$250 Co-Pay, 0%, Waive Deductible	35%, after Deductible
Ultrasound Charges	15%, after Deductible	35%, after Deductible
Note: The $250 Co-Payment does not include ultrasound charges.		
Routine Nursery Care / Newborn Care	15%, Waive Deductible	35%, Waive Deductible
Breast Pumps	No Charge	
Maximum per pregnancy	$165	
Breast Pumps are limited to one (1) per pregnancy.		

Plan 1 – Schedule of Benefits (Cont'd)

Medical Benefit	In-Network	*Out-of-Network
Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.		
Infertility (Diagnostic Testing Only)		Not Covered
Office Visit	$50 Co-Pay, 0%, Waive Deductible	Not Covered
All Other Services	15%, after Deductible	Not Covered
Mental Health Disorders/ Substance Use Disorders		
Inpatient	15%, after Deductible	35%, after Deductible
Outpatient	15%, after Deductible	35%, after Deductible
Mental Health Professional	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Psychiatrist (MD, PA, NP)	$50 Co-Pay, 0%, Waive Deductible	35%
Prosthetic/Orthotic Appliances	20%, after Deductible	Not Covered
Durable Medical Equipment	20%, after Deductible	Not Covered
Medical Supplies	20%, after Deductible	Not Covered
Organ Transplant	15%, after Deductible	Not Covered
Biofeedback – Specialist Provider	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	20 Visits	
Services limited to pain management, incontinence, mental health and bowel treatment.		
Temporomandibular Joint Syndrome (Diagnosis Only)	15%	Not Covered
Hearing Aids	50%	50%, after In-Network Deductible
Hearings aids are limited to $2,500 every five years for Participants age 19 and over. This limit will not apply to Participants under the age 19.		
Cochlear Implants	15%	
Diabetes Care Center and Diabetic Education		
Parkview Diabetes Care Center Only (Parkview criteria met)	No Charge	Not Covered
Parkview Diabetes Care Center Only (Parkview criteria not met or for additional sessions not required by Parkview criteria.)	15%, Waive Deductible	Not Covered
Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met)	No Charge	Not Covered
Second Opinion	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Minor Eye Treatment (Performed by a licensed Optometrist)		
Office Visit	$30 Co-Pay, 0%, Waive Deductible, per date of service	$30 Co-Pay, 0%, Waive Deductible, per date of service
Office Services	15%, after Deductible	15%, after In-Network Deductible
Certified Nurse-Midwife (Office or hospital setting only)	15%, after Deductible	Not Covered
Calendar Year Maximum Benefit	Unlimited	

Plan 1 – Schedule of Benefits (Cont'd)

Prescription Drug Plan	The Pharmacy at Parkview Retail – Up to a 90 day supply	Network Retail Pharmacies Retail – Up to a 30 day supply
Generic Co-Payments	$20	$50
Brand Name, Preferred Co-Payments	$40	$75
Brand Name, Non-Preferred Co-Payments	$60	$100
Specialty Drugs at PMC or USSC (excluding insulin) (30-day supply)	20% up to $200 per prescription	N/A
Approved Diabetic Supplies/ Medications (The Pharmacy at Parkview only)	100%, no Co-Payment	N/A

Approved Diabetic Supplies:
Approved insulin (insulin for insulin pumps included), oral medications, lancets, syringes, needles, meters and test strips at 100%, not subject to any Co-Payment, Co-insurance or Deductible, when purchased from the Pharmacy at Parkview (other pharmacies excluded) for members who have met Parkview's Diabetes Care Center's criteria. This excludes insulin pump supplies such as reservoirs, infusion sets, and tubing associated with the use of continuous insulin infusion pumps.

Intercept Program:
The Plan Administrator has procurement programs in place that may require participation in the Intercept program. Co-Pays may be waived for member enrollment and ongoing participation in the Intercept program. Participation in the Intercept program is voluntary. Covered medications may still be obtained subject to satisfying all other eligibility requirements and will result in a higher participant Co-Payment amount. Program participation bonuses are awarded for successful Intercept program participation only and are subject to the drug continuing to be included in the Intercept program. Program medications may be discontinued at any time without notice.

Coupons cannot be used unless prior consent from the Plan Administrator / Fund or a part of benefit sanctioned program specific to the Intercept program. The Plan Administrator has a part of its benefit, the Intercept program where program medications require a 40% Co-Pay.

Generic Drugs are required if available. If Participant purchases a Brand Name Drug when alternative Generic Drug is available, the Participant is responsible for the cost difference between the Brand Name and the Generic Drug, in addition to the Co-Payment.

Gastric Bypass/ Gastric Sleeve/Lap Banding Benefit

Gastric Bypass/ Gastric Sleeve/Lap Banding	50%, after Deductible	Not Covered
Lifetime Maximum Benefit	$25,000	

This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.

This benefit is separate from all other covered services and the co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime.

This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.

This benefit is separate from all other covered services and the Deductible and co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime. Required smoking cessation must be proven by urine testing at least 6 weeks prior to surgery. The urine test will be done at the time of insurance pre-authorization.

***** In-Network Benefits will apply for Out-of-Network Benefits as follows:
1. Procedures that cannot be performed by an In-Network Provider.
2. Hospital Admission or treatment in an Out-of-Network Facility or by an Out-of-Network Provider due to an Emergency.

* Out-of-Network charges will be reimbursed by the Plan based on Maximum Allowable Charge.

Benefits are subject to all other Plan exclusions, limitations and provisions and the applicable benefit maximums set forth in this Plan. Please review the Plan carefully to determine benefits available.

If a Participant fails to notify the pre-certification department of any Inpatient Hospital stay or PET scan as required in the section entitled "Pre-Certification Procedures," allowed charges will be reduced to the Out-of-Network benefit level.

"Out-of-Area Dependents: Dependent children and/or spouses that live in a different city than the covered Employee will have the ability to access an additional network of Providers through the MultiPlan network. Services received by a MultiPlan Provider will be paid at the In-Network level of benefits and covered Dependents will receive their own ID card with the network information. Services received outside the MultiPlan service area will be paid at the Out-of-Network level of benefits."

PARKVIEW MEDICAL CENTER, INC.,
d/b/a PARKCARE PLUS

SCHEDULE OF BENEFITS PLAN 2

Effective Date: January 1, 2021

The following is a summary of the benefits, subject to co-payments, deductibles, coinsurance and limitations, provided to you and any covered dependents. ***Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.*** PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.

Medical Benefit	**In-Network**	***Out-of-Network**
Calendar Year Deductible		
Individual	$750	$1,500
Two Family members	$1,500	$3,000
Three or more Family members	$2,250	$4,500
Coinsurance After Deductible or Co-Payment unless otherwise stated below	20%	40%
Calendar Year Out of Pocket maximum		
Individual	$5,500	$6,500
Family (Two or more Family members)	$9,500	$11,500
	Including any applicable Coinsurance, Deductibles, Co-Payments and Prescription Drug Charges.	
In-Network and Out-of-Network Deductible and Out of Pocket maximums will be considered integrated.		
Physician Services (In office)		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	40%, after Deductible
Co-Payment per visit – Specialist	$50 Co-Pay, 0%, Waive Deductible	40%, after Deductible
Office Injections	20%, after Deductible	40%, after Deductible
Office Surgery and Related Expenses	20%, after Deductible	40%, after Deductible
Office x-ray	20%, after Deductible	40%, after Deductible
Note: MRIs CT Scans, SPECT and PET Scans not covered in office setting.		
Office Laboratory (Approved office laboratory charges only)	No Charge	40%, after Deductible
Allergy Office Visit:		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Co-Payment per visit – Specialist	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Allergy Treatment including testing, injection, serum and supplies	No Charge	Not Covered
Urgent Care	$60 Co-Pay, 0%, Waive Deductible	$60 Co-Pay, 0%, Waive Deductible for Out-of-Area Emergencies only
Rapid Care	$30 Co-Pay, 0%, Waive Deductible	N/A
Telehealth (Mental Nervous Diagnosis Only)		
Co-Payment per visit – Primary Care Physician	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Co-Payment per visit – Specialist/ Psychiatrist	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Other Miscellaneous Physician Services	20%	40%
Preventive Care		
Grade A & B (Based on U.S. Preventive Services Task Force)	No Charge	Not Covered
All Other Services		
Physician's Office	No Charge	Not Covered
Other Outpatient Facilities	No Charge	
Chiropractic Care/ Osteopathic Manipulation	$30 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	12 Visits	

Plan 2 Schedule of Benefits (Cont'd)

Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.		
Medical Benefit	**In-Network**	***Out-of-Network**
Outpatient Laboratory		
LabCorp (Laboratory Services)	No Charge	Not Covered
Lab services that cannot be performed at LabCorp will be paid at the In-Network level of benefits.		
Outpatient Radiology	20%, after Deductible	40%, after Deductible
CT Scans, SPECT & PET Scans, MRIs	$200 Co-Pay, 20%, Waive Deductible	$200 Co-Pay, 40%, after Deductible
Pre-certification is required for PET Scans.		
Emergency Services		
Emergency Room Facility (Co-Pay waived if Admitted)	$300 Co-Pay, 20%, Waive Deductible	
Emergency Room Physicians	20%, Waive Deductible	
Ambulance Services	No Charge	
Hospital Services		
Inpatient/Outpatient	20%, after Deductible	40%, after Deductible
Hospital Room & Board Limitation	Average Semi-Private, Average Private	
Intensive Care Unit Limitation	Average Intensive Care	
Pre-certification is required for Inpatient Hospital Stays.		
Pre-Admission Testing	20%, after Deductible	40%, after Deductible
Inpatient and Outpatient charges for emergency room, radiology, anesthesiology, hospitalist and pathology services rendered by an Out-of-Network Physician will be paid the same as Covered Expenses for an In-Network Physician if such services are performed at an In-Network facility.		
Outpatient Rehabilitation/ Speech Therapy/ Physical Therapy/ Occupational Therapy	20%, after Deductible	Not Covered
Calendar Year Maximum	18 Visits	
BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY PER OCCURRENCE (DEFINED AS PER EPISODE, INJURY OR CONDITION). ADDITIONAL DAYS REQUIRED BEYOND THE MAXIMUM FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY WILL REQUIRE PRIOR AUTHORIZATION.		
Chemotherapy/ Radiation Therapy	20%, after Deductible	40%, after Deductible
Dialysis	20%, after Deductible	40%, after Deductible
Extended Care Services		
Home Health Care	20%, after Deductible	Not Covered
Skilled Nursing Facility	20%, after Deductible	40%, after Deductible
Calendar Year Maximum	45 Days	
Hospice Services	No Charge	Not Covered
Pregnancy		
All Maternity Physician charges (Delivery by PCP or OB/GYN)	$250 Co-Pay, 0%, Waive Deductible	40%, after Deductible
Ultrasound Charges	20%, after Deductible	40%, after Deductible
Note: The $250 Co-Payment does not include ultrasound charges.		
Routine Nursery Care / Newborn Care	20%, Waive Deductible	40%, Waive Deductible
Breast Pumps	No Charge	
Maximum per pregnancy	$165	
Breast Pumps are limited to one (1) per pregnancy.		

Plan 2 Schedule of Benefits (Cont'd)

Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.		
Medical Benefit	**In-Network**	***Out-of-Network**
Infertility (Diagnostic Testing Only)		
Office Visit	$50 Co-Pay, 0%, Waive Deductible	Not Covered
All Other Services	20%, after Deductible	Not Covered
Mental Health Disorders/ Substance Use Disorders		
Inpatient	20% after Deductible,	40%, after Deductible
Outpatient	20% after Deductible,	40%, after Deductible
Mental Health Professional	$30 Co-Pay, 0%, Waive Deducible	Not Covered
Psychiatrist (MD, PA, NP)	$50 Co-Pay, 0%, Waive Deductible	40%, after Deductible
Prosthetic/Orthotic Appliances	25%, after Deductible	Not Covered
Durable Medical Equipment	25%, after Deductible	Not Covered
Medical Supplies	20%, after Deductible	Not Covered
Organ Transplant	20%, after Deductible	Not Covered
Biofeedback – Specialist Provider	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	20 Visits	
Services limited to pain management, incontinence, mental health and bowel treatment.		
Temporomandibular Joint Syndrome (Diagnosis Only)	20%, after Deductible	Not Covered
Hearing Aids	50%, after Deductible	50%, after In-Network Deductible
Hearings aids are limited to $2,500 every five years for Participants age 19 and over. This limit will not apply to Participants under the age 19.		
Cochlear Implants	20%	
Diabetes Care Center and Diabetic Education		
Parkview Diabetes Care Center Only (Parkview criteria met)	No Charge	Not Covered
Parkview Diabetes Care Center Only (Parkview criteria not met or for additional sessions not required by Parkview criteria.)	20%, Waive Deductible	Not Covered
Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met)	No Charge	Not Covered
Second Opinion	$50 Co-Pay, 0%, Waive Deductible	Not Covered
Minor Eye Treatment (Performed by a licensed Optometrist)		
Office Visit	$30 Co-Pay, 0%, Waive Deductible, per date of service	$30 Co-Pay, 0%, Waive Deductible, per date of service
Office Services	15%, after Deductible	15%, after In-Network Deductible
Certified Nurse-Midwife (Office or hospital setting only)	20%, after Deductible	Not Covered
Calendar Year Maximum Benefit	Unlimited	

Plan 2 Schedule of Benefits (Cont'd)

Prescription Drug Plan	The Pharmacy at Parkview Retail – Up to a 90 day supply	Network Retail Pharmacies Retail – Up to a 30 day supply
Generic Co-Payments	$20	$50
Brand Name, Preferred Co-Payments	$40	$75
Brand Name, Non-Preferred Co-Payments	$60	$100
Specialty Drugs at PMC or USSC (excluding insulin) (30-day supply)	20% up to $200 per prescription	N/A
Approved Diabetic Supplies/ Medications (The Pharmacy at Parkview only)	100%, no Co-Payment	N/A
Approved Diabetic Supplies: Approved insulin (insulin for insulin pumps included), oral medications, lancets, syringes, needles, meters and test strips at 100%, not subject to any Co-Payment, Co-insurance or Deductible, when purchased from the Pharmacy at Parkview (other pharmacies excluded) for members who have met Parkview's Diabetes Care Center's criteria. This excludes insulin pump supplies such as reservoirs, infusion sets, and tubing associated with the use of continuous insulin infusion pumps.		
Intercept Program: The Plan Administrator has procurement programs in place that may require participation in the Intercept program. Co-Pays may be waived for member enrollment and ongoing participation in the Intercept program. Participation in the Intercept program is voluntary. Covered medications may still be obtained subject to satisfying all other eligibility requirements and will result in a higher participant Co-Payment amount. Program participation bonuses are awarded for successful Intercept program participation only and are subject to the drug continuing to be included in the Intercept program. Program medications may be discontinued at any time without notice. Coupons cannot be used unless prior consent from the Plan Administrator / Fund or a part of benefit sanctioned program specific to the Intercept program. The Plan Administrator has a part of its benefit, the Intercept program where program medications require a 40% Co-Pay.		
Generic Drugs are required if available. If Participant purchases a Brand Name Drug when alternative Generic Drug is available, the Participant is responsible for the cost difference between the Brand Name and the Generic Drug, in addition to the Co-Payment.		

Gastric Bypass/ Gastric Sleeve/Lap Banding Benefit

Gastric Bypass/ Gastric Sleeve/Lap Banding	50%, after Deductible	Not Covered
Lifetime Maximum Benefit	$25,000	
This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.		
This benefit is separate from all other covered services and the co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime.		
This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.		
This benefit is separate from all other covered services and the Deductible and co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime. Required smoking cessation must be proven by urine testing at least 6 weeks prior to surgery. The urine test will be done at the time of insurance pre-authorization.		

***** In-Network Benefits will apply for Out-of-Network Benefits as follows:

1. Procedures that cannot be performed by an In-Network Provider.
2. Hospital Admission or treatment in an Out-of-Network Facility or by an Out-of-Network Provider due to an Emergency.

* Out-of-Network charges will be reimbursed by the Plan based on Maximum Allowable Charge.

Benefits are subject to all other Plan exclusions, limitations and provisions and the applicable benefit maximums set forth in this Plan. Please review the Plan carefully to determine benefits available.

If a Participant fails to notify the pre-certification department of any Inpatient Hospital stay or PET scan as required in the section entitled "Pre-Certification Procedures," allowed charges will be reduced to the Out-of-Network benefit level.

"Out-of-Area Dependents: Dependent children and/or spouses that live in a different city than the covered Employee will have the ability to access an additional network of Providers through the MultiPlan network. Services received by a MultiPlan Provider will be paid at the In-Network level of benefits and covered Dependents will receive their own ID card with the network information. Services received outside the MultiPlan service area will be paid at the Out-of-Network level of benefits."

PARKVIEW MEDICAL CENTER, INC.,
d/b/a PARKCARE PLUS

SCHEDULE OF BENEFITS
HIGH DEDUCTIBLE HEALTH PLAN

Effective Date: January 1, 2021

The following is a summary of the benefits, subject to deductibles, coinsurance and limitations, provided to you and any covered dependents. ***Please note the Calendar Year Deductibles are always applicable unless the schedule states they are waived.*** PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.

Medical Benefit	**In-Network**	***Out-of-Network**
Calendar Year Deductible		
Individual	$2,800	$5,600
Two Family members	$5,600	$11,200
Three or more Family members	$5,600	$11,200
Coinsurance After Deductible unless otherwise stated below	30%	50%
Calendar Year Out of Pocket maximum		
Individual	$6,750	$8,150
Family (Two or more Family members)	$13,500	$15,300
	Including any applicable Coinsurance, Deductibles and Prescription Drug Charges.	
In-Network and Out-of-Network Deductible and Out of Pocket maximums will be considered integrated.		
Physician Services (In office)		
Office visit	30%, after Deductible	50%, after Deductible
Office x-ray Note: MRIs, CT Scans, SPECT and PET Scans not covered in office setting	30%, after Deductible	50%, after Deductible
Office Laboratory (approved office laboratory charges only)	30%, after Deductible	50%, after Deductible
Allergy Office visit	30%, after Deductible	Not Covered
Allergy Treatment including testing, injection, serum and supplies	30%, after Deductible	Not Covered
Telehealth (Mental Nervous Diagnosis Only)	30%, after Deductible	N/A
Other Miscellaneous Physician Services	30%, after Deductible	50%, after Deductible
Preventive Care Grade A & B (Based on U.S. Preventive Services Task Force)	No Charge	Not Covered
Breast Pump (Covered under Grade A & B) Maximum per pregnancy	No Charge $165	
Breast Pumps are limited to one (1) per pregnancy.		
All Other Services Physician's Office Other Outpatient Facilities	 No Charge No Charge	Not Covered
Chiropractic Care/ Osteopathic Manipulation	30%, after Deductible	Not Covered
Calendar Year Maximum	12 Visits	
Outpatient Laboratory	30%, after Deductible	Not Covered
Outpatient Radiology	30%, after Deductible	50%, after Deductible
CT Scans, SPECT & PET Scans, MRIs	30%, after Deductible	50%, after Deductible
Pre-certification is required for PET Scans.		

High Deductible Health Plan Schedule of Benefits (Cont'd)

Medical Benefit	**In-Network**	***Out-of-Network**
Emergency Services		
Emergency Room Facility	30%, after Deductible	
Emergency Room Physicians	30%, after Deductible	
Ambulance Services	30%, after Deductible	
Covered Expenses will be considered In-Network and will accumulate towards In-Network Deductible and Out of Pocket Maximum amounts.		
Hospital Services		
Inpatient/Outpatient	30%, after Deductible	50%, after Deductible
Hospital Room & Board Limitation	Average Semi-Private, Average Private	
Intensive Care Unit Limitation	Average Intensive Care	
Pre-certification is required for Inpatient Hospital Stays.		
Pre-Admission Testing	30%, after Deductible	50%, after Deductible
Inpatient and Outpatient charges for emergency room, radiology, anesthesiology, hospitalist and pathology services rendered by an Out-of-Network Physician will be paid the same as Covered Expenses for an In-Network Physician if such services are performed at an In-Network facility.		
Outpatient Rehabilitation/ Speech Therapy/ Physical Therapy/ Occupational Therapy	30%, after Deductible	Not Covered
Calendar Year Maximum	18 Visits	
BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY PER OCCURRENCE (DEFINED AS PER EPISODE, INJURY OR CONDITION). ADDITIONAL DAYS REQUIRED BEYOND THE MAXIMUM FOR PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY WILL REQUIRE PRIOR AUTHORIZATION.		
Chemotherapy/ Radiation Therapy	30%, after Deductible	50%, after Deductible
Dialysis	30%, after Deductible	50%, after Deductible
Extended Care Services		
Home Health Care	30%, after Deductible	Not Covered
Skilled Nursing Facility	30%, after Deductible	50%, after Deductible
Calendar Year Maximum	45 Days	
Hospice Services	30%, after Deductible	Not Covered
Pregnancy	30%, after Deductible	50%, after Deductible
Routine Nursery Care / Newborn Care	30%, after Deductible	50%, after Deductible
Infertility (Diagnostic Testing Only)	30%, after Deductible	Not Covered
Mental Health Disorders/ Substance Use Disorders		
Mental Health Professional	30%, after Deductible	Not Covered
Psychiatrist (MD, PA, NP)	30%, after Deductible	50%, after Deductible
Prosthetic/Orthotic Appliances	30%, after Deductible	Not Covered
Durable Medical Equipment	30%, after Deductible	Not Covered
Medical Supplies	30%, after Deductible	Not Covered
Organ Transplant	30%, after Deductible	Not Covered
Biofeedback – Specialist Provider	30%, after Deductible	Not Covered
Calendar Year Maximum	20 Visits	
Services limited to pain management, incontinence, mental health and bowel treatment.		

High Deductible Health Plan Schedule of Benefits (Cont'd)

Medical Benefit	**In-Network**	***Out-of-Network**
Temporomandibular Joint Syndrome (Diagnosis Only)	30%, after Deductible	Not Covered
Hearing Aids	30%, after Deductible	50%, after In-Network Deductible
Hearings aids are limited to $2,500 every five years for Participants age 19 and over. This limit will not apply to Participants under the age 19.		
Cochlear Implants	30%, after Deductible	
Covered Expenses will be considered In-Network and will accumulate towards In-Network Deductible and Out of Pocket Maximum amounts.		
Diabetes Care Center and Diabetic Education Parkview Diabetes Care Center Only (Parkview criteria met) Parkview Diabetes Care Center Only (Parkview criteria not met or for additional sessions not required by Parkview criteria.)	No Charge 30%, after Deductible	Not Covered Not Covered
Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met)	No Charge	Not Covered
Second Opinion	30%, after Deductible	Not Covered
Minor Eye Treatment (Performed by a licensed Optometrist)	30%, after Deductible	30%, after Deductible
Certified Nurse-Midwife (Office or hospital setting only)	30%, after Deductible	Not Covered
Calendar Year Maximum Benefit	Unlimited	

Prescription Drug Plan	**The Pharmacy at Parkview** **Retail – Up to a 90 day supply**	**Network Retail Pharmacies** **Retail – Up to a 30 day supply**
Generic Co-Payments Brand Name, Preferred Co-Payments Brand Name, Non-Preferred Co-Payments	30%, after Deductible 30%, after Deductible 30%, after Deductible	
Specialty Drugs at PMC or USSC (excluding insulin) (30-day supply)	30%, after Deductible	N/A
Approved Diabetic Supplies/ Medications (The Pharmacy at Parkview only)	100%, no Co-Payment	N/A
Approved Diabetic Supplies: Approved insulin (insulin for insulin pumps included), oral medications, lancets, syringes, needles, meters and test strips at 100%, not subject to any Co-Payment, Co-insurance or Deductible, when purchased from the Pharmacy at Parkview (other pharmacies excluded) for members who have met Parkview's Diabetes Care Center's criteria. This excludes insulin pump supplies such as reservoirs, infusion sets, and tubing associated with the use of continuous insulin infusion pumps.		
Generic Drugs are required if available. If Participant purchases a Brand Name Drug when alternative Generic Drug is available, the Participant is responsible for the cost difference between the Brand Name and the Generic Drug, in addition to the Co-Payment.		

Gastric Bypass/ Gastric Sleeve/Lap Banding Benefit

Gastric Bypass/ Gastric Sleeve/Lap Banding	50%, after Deductible	Not Covered
Lifetime Maximum Benefit	$25,000	
This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.		
This benefit is separate from all other covered services and the co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime.		
This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to the co-insurance.		
This benefit is separate from all other covered services and the Deductible and co-insurance paid will be separate from all other covered services. The Plan Participant may choose one of the above procedures once per lifetime. Required smoking cessation must be proven by urine testing at least 6 weeks prior to surgery. The urine test will be done at the time of insurance pre-authorization.		

***** In-Network Benefits will apply for Out-of-Network Benefits as follows:

1. Procedures that cannot be performed by an In-Network Provider.
2. Hospital Admission or treatment in an Out-of-Network Facility or by an Out-of-Network Provider due to an Emergency.

* Out-of-Network charges will be reimbursed by the Plan based on Maximum Allowable Charge.

Benefits are subject to all other Plan exclusions, limitations and provisions and the applicable benefit maximums set forth in this Plan. Please review the Plan carefully to determine benefits available.

If a Participant fails to notify the pre-certification department of any Inpatient Hospital stay or PET scan as required in the section entitled "Pre-Certification Procedures," allowed charges will be reduced to the Out-of-Network benefit level.

"Out-of-Area Dependents: Dependent children and/or spouses that live in a different city than the covered Employee will have the ability to access an additional network of Providers through the MultiPlan network. Services received by a MultiPlan Provider will be paid at the In-Network level of benefits and covered Dependents will receive their own ID card with the network information. Services received outside the MultiPlan service area will be paid at the Out-of-Network level of benefits."