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	<mark>\$500</mark>	<mark>\$1,000</mark>
Two Family members	<mark>\$1,000</mark>	<mark>\$2,000</mark>
Three or more Family members	<mark>\$1,400</mark>	<mark>\$2,800</mark>
Coinsurance After Deductible or Co-Payment	15%	35%
unless otherwise stated below	1070	33 70
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, Deduc	tibles, Co-Payments and
	Prescription Drug Charg	jes.
In-Network and Out-of-Network Deductible	e and Out of Pocket maximums will be conside	ered integrated.
Physician Convince (In office)		
Physician Services (In office)	\$20 Co Boy 09/ Mairo Doductible	250/ often Deductible
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 Office Surgery and Related Evanges	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)		
	\$20 Co Doy Of Mairo Dodystible	Not Covered
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
		\$60 Co-Pay, 0%,
Urgent Care	\$60 Co-Pay, 0%, Waive Deductible	Waive Deductible for
orgent care	φου co-i ay, 070, waive beductible	Out-of-Area
		Emergencies only
		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	No Charge	Not Covered
Task Force)	No Ollarge	INOL COVERED
All Other Services		
Physician's Office	No Charge	Not Covered
Other Outpatient Facilities	No Charge	
		1
Chiropractic Care/ Osteopathic Manipulation	\$30 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	12 Visits	1

Plan 1 Schedule of Benefits (Cont'd)

Please note the Calendar Year Deductibles a	are always applicable unless the schedule sta	tes they are waived.
Medical Benefit	In-Network	*Out-of-Network
Outpatient Laboratory		
LabCorp (Laboratory Services)	No Charge	Not Covered
Lab services that cannot be performe	ed at LabCorp will be paid at the In-Network level	or 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-certific	cation is required for PET Scans.	
Francisco Comitaca		
Emergency Services Emergency Room Facility (Co-Pay waived if Admitted)	\$300 Co-Pay, 15%, Waive D	Deductible
Emergency Room Physicians	15%, Waive Deductik	ole
Ambulance Services	No Charge	
Hospital Services		
Inpatient/Outpatient	15%, after Deductible	35%, after Deductible
Hospital Room & Board Limitation	Average Semi-Private, Avera	ge Private
Intensive Care Unit Limitation	Average Intensive Ca	are
Pre-certification	is required for Inpatient Hospital Stays.	
Pre-Admission Testing	150/ ofter Deductible	35%, after Deductible
Fre-Admission resting	15%, after Deductible	55%, after Deductible
Outpatient Rehabilitation/ Speech Therapy/ Physical Therapy/ Occupational Therapy Calendar Year Maximum	15%, after Deductible 18 Visits	Not Covered
BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR PHYS PER EPISODE, INJURY OR CONDITION). ADDITIONAL [ICAL, OCCUPATIONAL OR SPEECH THERAPY PER (· · · · · · · · · · · · · · · · · · ·
Chemotherapy/ Radiation Therapy	15%, after Deductible	35%, after Deductible
Dialysis	15%, after Deductible	35%, after Deductible
Extended Care Comings		
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
All Maternity Physician charges (Delivery by PCP	\$250 Co-Pay, 0%, Waive Deductible 15%, after Deductible	35%, after Deductible 35%, after Deductible
All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges	• • •	
All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges	15%, after Deductible	
All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges Note: The \$250 Co-Particle Nursery Care / Newborn Care	15%, after Deductible ayment does not include ultrasound charges. 15%, Waive Deductible	35%, after Deductible
All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges Note: The \$250 Co-Parameters Routine Nursery Care / Newborn Care Breast Pumps	15%, after Deductible ayment does not include ultrasound charges. 15%, Waive Deductible No Charge	35%, after Deductible
All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges Note: The \$250 Co-Paragraph Care Routine Nursery Care / Newborn Care Breast Pumps Maximum per pregnancy	15%, after Deductible ayment does not include ultrasound charges. 15%, Waive Deductible	35%, after Deductible

Plan 1 – Schedule of Benefits (Cont'd)

Modical Ropofit	In-Notwork	*Out-of Notwork
Medical Benefit	In-Network	*Out-of-Network
Please note the Calendar Year Deductibles a	are always applicable unless the schedule s	tates 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%
Dracthatic/Outhatic Applicance	200/ ofter Deductible	Not Covered
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	Not Covered
	ment, incontinence, mental health and bowel tr	eatment.
Corrido IIIIII to pain manage.		
Temporomandibular Joint Syndrome (Diagnosis	15%	Not Covered
Only)	1370	140t Govered
		50%, after In-Network
Hearing Aids	50%	Deductible
Hearings aids are limited to \$2,500 every five years for	or Participants age 19 and over. This limit will r	
	the age 19.	
	450/	
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	15%, Waive Deductible	Not Covered
	15%, Waive Deductible	Not Covered
criteria not met or for additional sessions not required by Parkview criteria.)	15%, Waive Deductible	Not Covered
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview	15%, Waive Deductible No Charge	Not Covered Not Covered
criteria not met or for additional sessions not required by Parkview criteria.)		
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview		
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion	No Charge	Not Covered
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed	No Charge	Not Covered
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist)	No Charge \$50 Co-Pay, 0%, Waive Deductible	Not Covered Not Covered
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed	No Charge	Not Covered Not Covered \$30 Co-Pay, 0%, Waive
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist) Office Visit	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per date of service	Not Covered Not Covered
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist)	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per	Not Covered Not Covered \$30 Co-Pay, 0%, Waive Deductible, per date of service
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist) Office Visit Office Services	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per date of service	Not Covered Not Covered \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after In-Network
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist) Office Visit Office Services Certified Nurse-Midwife (Office or hospital setting	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per date of service	Not Covered Not Covered \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after In-Network
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist) Office Visit Office Services	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after Deductible	Not Covered Not Covered \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after In-Network Deductible
criteria not met or for additional sessions not required by Parkview criteria.) Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met) Second Opinion Minor Eye Treatment (Performed by a licensed Optometrist) Office Visit Office Services Certified Nurse-Midwife (Office or hospital setting	No Charge \$50 Co-Pay, 0%, Waive Deductible \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after Deductible	Not Covered Not Covered \$30 Co-Pay, 0%, Waive Deductible, per date of service 15%, after In-Network Deductible

Plan 1 - Schedule of Benefits (Cont'd)

	The Pharmacy at Parkview	Network Retail Pharmacies
Prescription Drug Plan	Retail – Up to a 90 day supply	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-	20% up to \$200 per prescription	N/A
day supply)		
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	\$25,0	00
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 preauthorization.

- * 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.

are waived. PLEASE REFER TO THE LIMITATIONS	AND EXCLUSIONS FOR ADDITIONAL EX	PLANATIONS.
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	Ψ2,200	Ψ4,300
<u> </u>	20%	40%
otherwise stated below		
Calendar Year Out of Pocket maximum	A =	
Individual	\$5,500	\$6,500
Family (Two or more Family members)	\$9,500	\$11,500
	Including any applicable Coinsurance, De	eductibles, Co-Payments
	and Prescription Drug C	harges.
In-Network and Out-of-Network Deductible and Ou	t of Pocket maximums will be considere	d integrated.
		-
Physician Services (In office)		1
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	No Charge	Not Covered
supplies		
		\$60 Co-Pay, 0%,
Urgent Care	\$60 Co-Pay, 0%, Waive Deductible	Waive Deductible for
		Out-of-Area
		Emergencies only
Rapid Care	\$30 Co-Pay, 0%, Waive Deductible	N/A
- P	, , , , , , , , , , , , , , , , , , ,	
Telehealth (Mental Nervous Diagnosis Only)		
Co-Payment per visit — Primary Care Physician	\$30 Co-Pay, 0%, Waive Deductible	Not Covered
Co-Payment per visit — Filmary Care Physician Co-Payment per visit — Specialist/ Psychiatrist		
Co-Fayment per visit — Specialist/ Fsychiatrist	\$50 Co-Pay, 0%, Waive Deductible	Not Covered
		1 400/
Other Miscellaneous Physician Services	20%	40%
Preventive Care		
Grade A & B (Based on U.S. Preventive Services Task	No Charge	Not Covered
Force)	140 Ollarge	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]
		<u> </u>

Plan 2 Schedule of Benefits (Cont'd)

r rease note the Galendar real Deductiones are alw	ays applicable unless the schedule sta	tes 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 La	bCorp will be paid at the In-Network level	of benefits.	
Outpatient Radiology	20%, after Deductible	40%, after Deductible	
Catpatient Radiology	\$200 Co-Pay, 20%, Waive	\$200 Co-Pay, 40%, after	
CT Scans, SPECT & PET Scans, MRIs	Deductible	Deductible	
Pre-certification is	s required for PET Scans.	Deddelible	
Emergency Services	M000 O. D. 000/ M/ . D. 1		
Emergency Room Facility (Co-Pay waived if Admitted)	\$300 Co-Pay, 20%, Waive Deductible		
Emergency Room Physicians	20%, Waive Ded	uctible	
Ambulance Services	No Charge		
Hospital Services	200/ after Deductible	400/ often Destroich	
Inpatient/Outpatient	20%, after Deductible	40%, after Deductible	
Hospital Room & Board Limitation	Average Semi-Private, A	•	
Intensive Care Unit Limitation	Average Intensiv	e Care	
Pre-certification is requi	red for Inpatient Hospital Stays.		
Pre-Admission Testing	20%, after Deductible	40%, after Deductible	
Outpatient Rehabilitation/ Speech Therapy/ Physical Therapy/ Occupational Therapy Calendar Year Maximum BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR PHYSICAL, O PER EPISODE, INJURY OR CONDITION). ADDITIONAL DAYS RI	EQUIRED BEYOND THE MAXIMUM FOR PHY	Not Covered OCCURRENCE (DEFINED AS	
SPEECH THERAPY WILL I	REQUIRE PRIOR AUTHORIZATION.		
	REGULET MONTO THORIZATION.		
Chemotherapy/ Radiation Therapy	20%, after Deductible		
.,		SICAL, OCCUPATIONAL OR	
Dialysis	20%, after Deductible	SICAL, OCCUPATIONAL OR 40%, after Deductible	
Dialysis Extended Care Services	20%, after Deductible 20%, after Deductible	40%, after Deductible 40%, after Deductible	
Dialysis Extended Care Services Home Health Care	20%, after Deductible 20%, after Deductible 20%, after Deductible	40%, after Deductible 40%, after Deductible Not Covered	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible	40%, after Deductible 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days	40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible	40%, after Deductible 40%, after Deductible Not Covered	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN)	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible	A0%, after Deductible 40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible Not Covered 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible 20%, after Deductible	A0%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible	A0%, after Deductible 40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible Not Covered 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible 20%, after Deductible	A0%, after Deductible 40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible Not Covered 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges Note: The \$250 Co-Payment	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible 20%, after Deductible does not include ultrasound charges.	A0%, after Deductible 40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible Not Covered 40%, after Deductible 40%, after Deductible 40%, after Deductible	
Dialysis Extended Care Services Home Health Care Skilled Nursing Facility Calendar Year Maximum Hospice Services Pregnancy All Maternity Physician charges (Delivery by PCP or OB/GYN) Ultrasound Charges Note: The \$250 Co-Payment	20%, after Deductible 20%, after Deductible 20%, after Deductible 20%, after Deductible 45 Days No Charge \$250 Co-Pay, 0%, Waive Deductible 20%, after Deductible does not include ultrasound charges.	A0%, after Deductible 40%, after Deductible 40%, after Deductible Not Covered 40%, after Deductible Not Covered 40%, after Deductible 40%, after Deductible 40%, after Deductible	

Plan 2 Schedule of Benefits (Cont'd)

Please note the Calendar Year Deductibles are always app	licable 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
M (111 H) B: 1 (0.1 (11 B)		T
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
	ATO 0 B 00/ 14/ 1	T
Biofeedback - Specialist Provider	\$50 Co-Pay, 0%, Waive Deductible	Not Covered
Calendar Year Maximum	20 Visits	
Services limited to pain management, incontine	nce, mental health and bowel treatmen	nt.
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 a the age 1		ly to Participants under
the age i	3 .	
Cochlear Implants	20%	
Diabetes Care Center and Diabetic Education Parketing Diabetes Care Center Only (Parketing aritoria mot)	No Chargo	Not Covered
Parkview Diabetes Care Center Only (Parkview criteria met) Parkview Diabetes Care Center Only (Parkview criteria not met or	No Charge	
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
	\$50 Co-Pay, 0%, Waive	
Second Opinion	Deductible	Not Covered
Minor Eye Treatment (Performed by a licensed Optometrist)		
minor Lyo Treatment (i chomica by a licensed Optometrist)	***	\$30 Co-Pay, 0%, Waive
Office Visit	\$30 Co-Pay, 0%, Waive Deductible, per date of service	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		

Plan 2 Schedule of Benefits (Cont'd)

	The Pharmacy at Parkview	Network Retail Pharmacies
Prescription Drug Plan	Retail – Up to a 90 day supply	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-	20% up to \$200 per prescription	N/A
day supply)		
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	\$25,0	00
This benefit will only be paid when the procedure is deemed Medically Necessary. Follow-up visits will also be covered subject to		

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 preauthorization.

- 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.

T LEAGE REFER TO THE ENVIRTATIONS AND		
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	30%	50%
below	30 /6	30 76
Calendar Year Out of Pocket maximum		
Individual	\$6,750	\$8,150
Family (Two or more Family members)	\$13,500	\$15,300
	Including any applicable Co	oinsurance, Deductibles and
	Prescription [Orug Charges.
In-Network and Out-of-Network Deductible and O	ut of Pocket maximums will be c	onsidered integrated.
Physician Services (In office)		
Office visit	30%, after Deductible	50%, after Deductible
Office x-ray	30%, after Deductible	50%, after Deductible
Note: MRIs, CT Scans, SPECT and PET Scans		
not covered in office setting		
Office Laboratory (approved office laboratory charges	30%, after Deductible	50%, after Deductible
only)		
Allergy Office visit	30%, after Deductible	Not Covered
Allergy Treatment including testing, injection, serum	30%, after Deductible	Not Covered
and supplies		
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	No Charge	Not Covered
Task Force) Breast Pump (Covered under Grade A & B)		harge
Maximum per pregnancy	1NO C \$1	65
Breast Pumps are limite	ed to one (1) per pregnancy.	
All Other Services	(1) [21]	
Physician's Office	No Charge	Not Covered
Other Outpatient Facilities	No Charge	
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
	equired 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
Ambulanaa Camiaaa	200/ often	Dodustible
Ambulance Services Covered Expenses will be considered In-Network and will accumula	30%, after	
Covered Expenses will be considered in-Network and will accumula	tie towards III-Network Deductible and	d Out of Pocket Maximum amounts.
Hospital Services		
Inpatient/Outpatient	30%, after Deductible	50%, after Deductible
Hospital Room & Board Limitation	Average Semi-Priva	
Intensive Care Unit Limitation	Average Interded Character Hamilton Character	ensive Care
Pre-certification is require	ed for Inpatient Hospital Stays.	
Pre-Admission Testing	30%, after Deductible	50%, after Deductible
Inpatient and Outpatient charges for emergency room, rendered by an Out-of-Network Physician will be paid th such services are perfor	radiology, anesthesiology, hosp e same as Covered Expenses t med at an In-Network facility.	italist and pathology services for an In-Network Physician if
Outpatient Rehabilitation/ Speech Therapy/	30%, after Deductible	
Physical Therapy/ Occupational Therapy		Not Covered
Calendar Year Maximum	18 Visits	
BENEFITS ARE LIMITED TO 18 VISITS TOTAL FOR F		
OCCURRENCE (DEFINED AS PER EPISODE, INJU	JRY OR CONDITION). ADDITI	IONAL DAYS REQUIRED
BEYOND THE MAXIMUM FOR PHYSICAL, OCCUPA AUTHO	DRIZATION.	PY WILL REQUIRE PRIOR
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 E	
Hospice Services	30%, after Deductible	Not Covered
Pregnancy	30%, after Deductible	50%, after Deductible
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Routine Nursery Care / Newborn Care	30%, after Deductible	50%, after Deductible
Infertility (Diagnostic Testing Only)	30%, after Deductible	Not Covered
moranty (Bidghootio Footing Chry)	5070, artor Doddonoro	1401 0040100
Mental Health Disorders/ Substance Use Disorders		
Mental Health Professional	30%, after Deductible	Not Covered
Psychiatrist (MD, PA, NP)	30%, after Deductible	50%, after Deductible
Proofbatio/Orthotic Appliances	200/ ofter Deductible	Not Covered
Prosthetic/Orthotic Appliances	30%, after Deductible	Not Covered
Durable Medical Equipment	30%, after Deductible	Not Covered
Medical Supplies	30%, after Deductible	Not Covered
medical oupplies	50 70, arter Deductible	INOL COVERED
Organ Transplant	30%, after Deductible	Not Covered
Biofeedback - Specialist Provider	30%, after Deductible	
Calendar Year Maximum	20 Visits	Not Covered
Services limited to pain management, incontinence,	mental health and bowel	
ueaunent.		
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 Participant	s for Participants age 19 and over ts under the age 19.	This limit will not apply to	
Cochlear Implants	30% after	30%, after Deductible	
	late 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	No Charge	Not Covered	
criteria not met or for additional sessions not required by Parkview criteria.)	30%, after Deductible	Not Covered	
Diabetic Supplies/ Medications (Parkview Pharmacy only) (Parkview criteria met)	No Charge	Not Covered	
Second Opinion	30%, after Deductible	Not Covered	
	3370, 4.113. 2 3 4 4 5 1.13	. 101 001 010	
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		
	The Pharmacy at Parkview	Network Retail Pharmacies	
Prescription Drug Plan	Retail – Up to a 90 day supply	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 me not subject to any Co-Payment, Co-insurance or Deductible, excluded) for members who have met Parkview's Diabetes C	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				

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