

MEDICAL SCHEDULE OF BENEFITS: \$1,500 PLAN

| \$1,500 PLAN | PARTICIPATING PROVIDERS | NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges) |
|---|---|---|
| LIFETIME MAXIMUM BENEFIT | Unlimited | |
| PLAN YEAR MAXIMUM BENEFIT | Unlimited | |
| PLAN YEAR DEDUCTIBLE | | |
| Single | \$1,500 | \$3,000 |
| Family | \$3,000 | \$6,000 |
| PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance) | | |
| Single | N/A | \$2,000 |
| Family | N/A | \$4,000 |
| TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card) | | |
| Single | \$8,150 | Unlimited |
| Family | \$16,300 | Unlimited |
| MEDICAL BENEFITS | | |
| Ambulance Services | 100% after Deductible | Paid at the Participating Provider level of benefits |
| Chiropractic Care/Spinal Manipulation | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| Diagnostic Testing, X-Ray and Lab Services (Outpatient) | 100% after Deductible | 50% after Deductible |
| Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy) | 100% after Deductible | 50% after Deductible |
| Durable Medical Equipment (DME) | 100% after Deductible | 50% after Deductible |
| Emergency Services/Emergency Room Services | \$200 Copay, then 100%; Deductible waived | Paid at the Participating Provider level of benefits |
| NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital. | | |
| Foot Orthotics | 100% after Deductible | 50% after Deductible |
| Plan Year Maximum Benefit | 1 orthotic per foot | |
| NOTE: Plan Year maximum does not apply to foot orthotics for diabetes. | | |
| Home Health Care | 100% after Deductible | 50% after Deductible |
| Hospice Care | 100% after Deductible | 50% after Deductible |

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|---|--|--|
| Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges) | | |
| Inpatient | 100% after Deductible | 50% after Deductible |
| Room and Board Allowance | Semi-Private Room Rate* | Semi-Private Room Rate* |
| Intensive Care Unit | ICU/CCU Room Rate | ICU/CCU Room Rate |
| Miscellaneous Services & Supplies | 100% after Deductible | 50% after Deductible |
| Outpatient | 100% after Deductible | 50% after Deductible |
| * A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. | | |
| Maternity (non-facility charges)* | | |
| Preventive Prenatal and Breastfeeding Support (other than lactation consultations) | 100%; Deductible waived | 50% after Deductible |
| Lactation Consultations | 100%; Deductible waived | 100%; Deductible waived |
| All Other Prenatal, Delivery and Postnatal Care | 100% after Deductible | 50% after Deductible |
| * See Preventive Services under Eligible Medical Expenses for limitations. | | |
| Mental Disorders and Substance Use Disorders | | |
| Inpatient | 100% after Deductible | 50% after Deductible |
| Outpatient (includes Telemedicine) | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized. | | |
| Morbid Obesity | Paid based on place of service | Paid based on place of service |
| Lifetime Maximum Benefit | 1 Surgical Procedure | |
| Nutritional Supplements | 100%; Deductible waived | 50% after Deductible |
| Occupational Therapy (Outpatient) (OT) | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| Physical Therapy (Outpatient) (PT) | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| Physician's Services | | |
| Inpatient/Outpatient Services | 100% after Deductible | 50% after Deductible |
| Office Visit Charge & Telemedicine | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| All Other Services and Supplies Rendered During an Office Visit | 100% after Deductible | 50% after Deductible |
| Physician Office Surgery | 100% after Deductible | 50% after Deductible |
| NOTE: The Copay will be waived for services rendered at OB-GYN Associates of Erie, P.C. (TIN 25-1653555) and Primary Care Associates of Erie (TIN 25-1653555). | | |

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|--|--|--|
| Preventive Services and Routine Care | | |
| Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately) | 100%; Deductible waived | 50% after Deductible |
| Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above) | 100%; Deductible waived | 50% after Deductible |
| Private Duty Nursing | 100% after Deductible | Paid at the Participating Provider level of benefits |
| Plan Year Maximum Benefit | 240 hours | |
| Regenexx Stem Cell Treatment (received by Regenexx Corporate Provider Network only) | 100%; Deductible waived | N/A |
| Respiratory/Pulmonary Therapy | 100% after Deductible | Paid at the Participating Provider level of benefits |
| Plan Year Maximum Benefit | 20 visits | |
| Retail Clinic | | |
| Retail Clinic Visit Charge | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| All Other Services and Supplies Rendered During a Visit | 100% after Deductible | 50% after Deductible |
| Skilled Nursing Facility and Rehabilitation Facility | 100% after Deductible | 50% after Deductible |
| Combined Plan Year Maximum Benefit | N/A | 100 days |
| Speech Therapy (Outpatient) (ST) | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| Plan Year Maximum Benefit | 20 visits | |
| Transplants | 100% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers) | 50% after Deductible |
| * Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible. | | |
| NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness. | | |
| Urgent Care Facility | | |
| Facility Visit Charge | \$25 Copay, then 100%; Deductible waived | 50% after Deductible |
| All Other Services and Supplies Rendered During a Visit | 100% after Deductible | 50% after Deductible |

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|--|--------------------------------|--|
| Wig (see Eligible Medical Expenses) | 100% after Deductible | 50% after Deductible |
| Maximum Benefit | \$500 per course of treatment | |
| All Other Eligible Medical Expenses | 100% after Deductible | 50% after Deductible |

PRESCRIPTION DRUG SCHEDULE OF BENEFITS: \$1,500 PLAN

| BENEFIT DESCRIPTION | BENEFIT |
|--|-----------------------|
| NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider. | |
| TOTAL OVERALL PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) | |
| Single | \$8,150 |
| Family | \$16,300 |
| Retail Pharmacy: 30-day supply | |
| Generic Drug | \$15 Copay |
| Formulary Drug | \$30 Copay |
| Non-Formulary Drug | \$50 Copay |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |
| Mandatory Specialty Pharmacy Program: 30-day supply | |
| Specialty Drug | |
| Specialty Drugs Not Available Through the PrudentRx Copay Program | |
| Generic Drug | \$15 Copay |
| Formulary Drug | \$30 Copay |
| Non-Formulary Drug | \$50 Copay |
| Enrolled and Available in the PrudentRx Copay Program | \$0 Copay |
| Not Enrolled and Available in the PrudentRx Copay Program | 30% Copay |
| NOTE: Specialty drugs MUST be obtained directly from the Specialty Pharmacy Program. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons. | |
| NOTE: The PrudentRx Copay Program assists individuals by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% Copay if those drugs are available through the program and you do not enroll. However, enrolled individuals who get a copay card for their Specialty Drug (if applicable), will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Co-Pay Program. | |
| CVS Maintenance Choice Voluntary: 90-day supply | |
| Generic Drug | \$30 Copay |
| Formulary Drug | \$60 Copay |
| Non-Formulary Drug | \$100 Copay |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |
| Mail Order Pharmacy: 90-day supply | |
| Generic Drug | \$30 Copay |
| Formulary Drug | \$60 Copay |
| Non-Formulary Drug | \$100 Copay |
| Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS) | \$0 Copay (100% paid) |

CVS Maintenance Choice Voluntary

This Plan allows for purchase of a 30-day supply of maintenance drugs at any retail pharmacy. A 90-day supply of maintenance drugs must be purchased at a CVS retail pharmacy only or through the mail order program. For additional information, please contact the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Formulary or Non-Formulary Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Formulary or Non-Formulary Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Formulary or Non-Formulary Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary

Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

CVS True Accumulation Program

Some Specialty Drugs may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such Specialty Drug where third-party copayment assistance is used, the Covered Person shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, Specialty Drugs. The PrudentRx Copay Program will assist individuals in obtaining copay assistance from drug manufacturers to reduce an individual's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible persons will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call (800) 578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications, in that case, you must speak to someone at PrudentRx at (800) 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% Copay on Specialty Drugs that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copays for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copay assistance program, do not count towards your Out-of-Pocket Maximum. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.