SCHEDULE OF BENEFITS – 2000 PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	**Level I Benefit** **Level II PPO Benefit**	**Level II Non-PPO Benefit**
Plan Year Deductible • Per Covered Person • Family Limit*	 $2,000 $4,000	 $2,000 $4,000
Benefit Percentage (unless otherwise noted)	80%	70%
Coinsurance Limit • Per Covered Person • Family Limit*	 $2,000 $4,000	 $2,000 $4,000
Annual Out-of-Pocket Maximum (Includes Deductible, Coinsurance Limit, Medical Copays and Prescription Drug Copays) • Per Covered Person • Family Limit*	 $7,150 $14,300	 $7,150 $14,300

NOTE: The Plan Year Deductibles, Coinsurance Limit and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Plan Year. Any applicable Maximums for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges. The Coinsurance reflected in this Schedule of Benefits is the Plan's Benefit Percentage. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

SCHEDULE OF BENEFITS – 2000 PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

Utilization Review (UR) Notification Requirements		
Non-compliance Penalty per Hospital/Facility Inpatient Admission and Outpatient Surgery: 20% reduction in benefits Non-compliance penalty applies for failure to notify Utilization Review. See Utilization Review (UR) Program section.		
Hospital/Facility Inpatient Services		
Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	UR Notification required or penalty applies.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	80% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible waived	Payable under covered mother's Claim.
Skilled Nursing Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 100 days per Plan Year. UR Notification required or penalty applies.
Rehabilitation Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	UR Notification required or penalty applies.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	UR Notification required or penalty applies.
Emergency Room (Hospital Emergency Room Services/ Independent Freestanding Emergency Department)		
Emergency Room	100% of Allowable Claim Limits $150 ER Copay applies Deductible waived ER Copay waived if admitted Inpatient	UR Notification required if admitted Inpatient or penalty applies.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) **All Other Diagnostic Lab and X-ray**	80% of Allowable Claim Limits Deductible applies 80% of Allowable Claim Limits Deductible applies	
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.

SCHEDULE OF BENEFITS – 2000 PLAN (Cont'd.)

Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine) Additional Colonoscopy (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	Routine limited to beginning at age 45 or Family history of colon cancer. UR Penalty waived for routine colonoscopy.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	UR Notification required or penalty applies.
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ **Psychological Testing/** **Outpatient Therapy** (including group therapy and Family counseling)	80% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services and Cardiac Rehabilitation		
Physical Therapy	100% of Allowable Claim Limits after $40 Copay; Deductible waived	Limited to 30 visits per Plan Year.
Occupational Therapy	100% of Allowable Claim Limits after $40 Copay; Deductible waived	Limited to 30 visits per Plan Year.
Speech Therapy	100% of Allowable Claim Limits after $40 Copay; Deductible waived	Limited to 30 visits per Plan Year.
Cardiac Rehabilitation	100% of Allowable Claim Limits after $40 Copay; Deductible waived	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	UR Notification required for Inpatient or penalty applies. For Homebound Hospice contact Utilization Review for Coordination of Care.
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	100% of Allowable Claim Limits after $40 Copay Deductible waived	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	80% of Allowable Claim Limits Deductible applies	UR Notification required for Inpatient or penalty applies.

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network). The "Level II PPO Benefit" also applies in the following exceptions:

1. If a PPO Provider refers a Covered Person to a Physician who is not in the PPO Network because there is no appropriate specialist available among PPO Providers;
2. If a Covered Person has no choice of PPO Providers in the specialty that the Covered Person is seeking within the PPO service area;
3. If a Covered Person receives Medically Necessary services from a Non-PPO Provider because the Covered Person is living or traveling outside of the geographic zip code area serviced by the PPO (Out-of-Area); or
4. If a Covered Person seeks treatment in a Hospital or Ambulatory Surgery Center, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon, on-call Physician/specialist; or
5. If a PPO Provider sends diagnostic x-ray and/or lab tests to a Non-PPO Provider for interpretation.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by a PPO Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

1. Emergency Services; and
2. Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Physician Services			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Maximum Benefits, Limits & Provisions**
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – 2000 PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Emergency Room Physician	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies.	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Initial Visit	100% of PPO rate after $20 Copay Deductible waived (Office Visit Copay does not apply after initial visit)	100% of Allowable Claim Limits after $20 Copay Deductible waived (Office Visit Copay does not apply after initial visit)	
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	80% of PPO rate Deductible waived	70% of Allowable Claim Limits Deductible waived	Payable under covered mother's Claim.
KIS Imaging Radiological Benefit (CT scans, MRIs and PET scans)	80% of KIS Imaging negotiated rate PPO Deductible and PPO Out-of-Pocket Maximum apply		Call 888-458-8746 to schedule.
***Lab and X-ray Benefits** (procedures performed in Physician's office, Outpatient Hospital, Freestanding x-ray Facility or independent lab)			
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) When not performed by KIS Imaging.	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
All Other Lab/X-ray	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
All Covered Physician Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Voluntary Second or Third Opinion (exam) • Medical Supplies • Retail Limited Services Clinic	100% of PPO rate after $20 Copay PCP $40 Copay Specialist Deductible waived	100% of Allowable Claim Limits $20 Copay PCP $40 Copay Specialist Deductible waived	
NOTE: For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.			
Office Surgery	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
***Sterilization Procedures** (vasectomies)	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
Contraceptive Injections, Implants, IUDs and Diaphragms	100% of PPO rate Copay and Deductible waived	100% of Allowable Claim Limits Copay and Deductible applies	
Allergy Testing, Serum and Injections	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
Office Lab and X-ray (except Select Diagnostic Medical Procedures)	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/Group Therapy/*Psychological Testing	100% of PPO rate after $20 Copay Deductible waived	100% of Allowable Claim Limits $20 Copay Deductible waived	
Chiropractic Services (Including x-rays)	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	Limited to 20 visits per Plan Year.
Urgent Care Facility (Minor Emergency Medical Clinic)	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	
All Other Covered Physician Services	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Physical Therapy**	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	Limited to 30 visits per Plan Year.
***Occupational Therapy**	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	Limited to 30 visits per Plan Year.
***Speech Therapy**	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	Limited to 30 visits per Plan Year.
***Cardiac Rehabilitation**	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits $40 Copay Deductible waived	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/Dialysis** Wig (provided for hair loss during Chemotherapy/ Radiation Therapy)	80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies 70% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. Limited to $500 Lifetime Maximum Benefit.
***Durable Medical Equipment**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
***Orthotic Devices/ Orthotic Insoles**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
***Prosthetics**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	
***Home Health Care Services**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	Limited to 90 visits per Plan Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
***Private Duty Nursing**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	Limited to 10 days per Plan Year.
***Hospice** Bereavement Counseling	80% of PPO rate Deductible 100% of PPO rate after $20 Copay Deductible waived	70% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits $20 Copay Deductible waived	UR Notification required for Inpatient Hospice. For Homebound Hospice contact Utilization Review for Coordination of Care.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Diabetic Self-Management Training Office Visit	100% of PPO rate after $20 Copay PCP $40 Copay Specialist Deductible waived	100% of Allowable Claim Limits $20 Copay PCP $40 Copay Specialist Deductible waived	
***Ambulance — Air or Ground Transportation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits; PPO Deductible and PPO Out-of-Pocket apply	
UCM Digital Health Consultation (telephone or online – unlimited access)	100%; no Copay or Consultation fee		Call 844-4-VIP DOC (844-484-7362).
***All Other Covered Expenses**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Company's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

SCHEDULE OF BENEFITS – 2000 PLAN (Cont'd.)

Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Limits & Provisions**
All Covered Wellness Benefits	100% of PPO rate Copay and Deductible waived	100% of Allowable Claim Limits Copay and Deductible waived	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap smear and other routine lab
4. Annual Mammogram (routine)
5. Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. Routine Colonoscopy (including polyp removal - beginning at age 45 or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Plan Year with four tobacco cessation counseling sessions per attempt)
15. All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

ORGAN TRANSPLANT POLICY

Organ and tissue transplant coverage is provided under a separate insurance policy by Tokio Marine HCC – Stop Loss Group (TMHCC) and is issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this Major Medical Plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network Provider access.

Pre-Authorization of Transplant Services
Pre-authorization of transplant services is required prior to seeing a transplant Provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE - Transplant Network
In order to obtain 100% in-network benefits, you must use Providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network Provider that are not covered by the TMHCC policy are subject to this Medical Plan's benefits and the payment terms and conditions of the transplant network Provider's contracted rates.

For more information, contact your Medical Plan Administrator and/or human resources department.

NOTE: The Company's fully insured Organ Transplant Policy is the Primary payer for Organ, Tissue and Bone Marrow Transplants. In the event the Company's Organ Transplant Policy does not cover some or all transplant related charges incurred by a Covered Person due to a pre-existing condition exclusion limitation, this Plan will consider the charges based on benefits below as the Secondary payer. See Coordination With Organ Transplant Policy section of this Plan Document.

Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	80% of Program rate PPO Deductible applies	70% of Usual and Customary fees Non-PPO Deductible applies	UR Notification required for a transplant procedure or penalty applies. Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	80% of Program rate PPO Deductible applies	70% of Usual and Customary fees Non-PPO Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% PPO Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

GPA HW CANCER CARE PROGRAM

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. The GPA HW Cancer Care Program will utilize specialized care coordination nurses to provide patient education and support while coordinating with the patient, Providers, Center of Excellence (COE), and Plan benefits. The principles for Certified Case Management and the guidelines of nationally recognized organizations, MCG (formerly Milliman Care Guidelines) and National Comprehensive Cancer Network (NCCN), including the NCCN Compendium of Care, will be utilized in the review of care for Medical Necessity and evidence-based medicine. In the event care is requested that is outside of the nationally recognized criteria, independent medical reviews by a Board Certified and actively practicing Oncologist or Physician of like specialty will be completed to ensure standard of medical care is provided for Plan Participants. GPA HW Cancer Care Program may utilize a panel of three (3) Board Certified and actively practicing Oncologists or Physicians of like specialty in the event of appeals. Should oncology care at a Center of Excellence benefit the patient and Plan, the HW Cancer Care Program nurse will gather the data from at least two (2) independent COE contracting sources. The COE contracts will be reviewed for comprehensiveness of contract and the COE's quality outcomes before selection. GPA HW Cancer Care Program will not limit member participation based on type of cancer.

SECOND OPINION

The Plan provides coverage for a Second Opinion through utilization of the Pathology/DiagnosticCOE, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a Pathology/DiagnosticCOE to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Molecular testing is a covered benefit when coordinated by GPA's HealthWatch department's Cancer Care nurse.

CLINICAL TRIAL BENEFITS

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.

e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

    i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and

2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

Covered Persons are encouraged to contact GPA's HealthWatch department's Cancer Care Program at 1-800-843-6705 option 6 or cancercare@gpatpa.com for further information on clinical trial coverage.

Questions: If there are any questions regarding coverage or a specific provision of GPA's HealthWatch department's Cancer Care Program, please contact the Plan Administrator at 1-800-843-6705 option 6 or email cancercare@gpatpa.com.

PRESCRIPTION DRUG PLAN BENEFITS

Prescription Drug Copays/Expenses apply to satisfy the Annual Out-of-Pocket Maximum. After the separate Prescription Drug Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.

Prescription Card Service	**100% after applicable Copay**
Supply Limit	30 days
Formulary Generic Drugs	$4 Copay
Non-Formulary Generic Drugs	$20 Copay
Formulary Brand Name Drugs	$40 Copay
Non-Formulary Brand Name Drugs	$70 Copay
Mail Order Service	**100% after applicable Copay**
Supply Limit	90 days
Formulary Generic Drugs	$8 Copay
Non-Formulary Generic Drugs	$40Copay
Formulary Brand Name Drugs (Tier 2)	$80 Copay
Non-Formulary Brand Name Drugs (Tier 3)	$140 Copay
Specialty Drugs*	$70 Copay
Supply Limit	30 days

* Specialty Drugs can be obtained through the Prescription Drug Plan's Specialty Pharmacy, Mail Order Service or a retail pharmacy.

NOTE: Medications required for Preventive Care services may be covered at 100% with no Copay.

For Coordination of Benefits when this Plan is secondary, file the prescription receipt with the Drug Plan. Call the Prescription Claims Help Desk for a Claim form. See Plan Participant identification card for the phone number.

If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Non-Specialty Generic and Brand Name Drug copayments apply separately to each prescription and refill and do not apply to the Plan Deductible. To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

Therapeutic Substitution

Therapeutic Substitution is a Physician oriented service designed to increase the utilization of more cost effective products. Substitutes are made for Non-Formulary Brand Name Drugs with either Generic or similar Formulary Brand Name Drugs in the same therapeutic class.

DEFINITIONS

Brand Name Drugs

Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Brand Name Drugs listed as "Non-Formulary" or not listed. Brand Name Drugs with Generic alternatives are considered "Non-Formulary."

Generic Drugs

Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Specialty Drugs
Specialty pharmaceuticals include biotech Drugs produced using living organisms which are high cost or injectable Drugs that require heightened patient management and support.

Step Therapy
Step Therapy is the practice of starting Drug therapy for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives if necessary.

Maximum Allowable Cost
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. **Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available, the Covered Person is required to pay the difference in cost between the Brand and Generic product in addition to the usual Brand Copay (applies to Prescription Card only and Mail Order).**

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Drug Review
The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs
The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drug is covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs may require authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs
1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain Legend Drugs that may be excluded);
2. Insulin on prescription;
3. Disposable insulin needles/syringes, test strips and lancets on prescription;
4. Compounded medications of which at least one ingredient is a prescription legend Drug;
5. All FDA approved women's contraceptive Drugs and methods ($0 Copay Generic only; if no Generic available, $0 Copay applies to Brand);

6. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms ($0 Copay Generic only; if no Generic available, $0 Copay applies to Brand; two (2) 90-day supply limits per Plan Calendar Year); and
7. Specialty Drugs.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugs that may be covered for preventive treatment.

Prescription Drug Plan – Excluded Drugs

1. Drugs for Cosmetic purposes;
2. Weight loss medications;
3. Immunization agents (except immunizations and vaccines as required for Preventive Care services; $0 Copay Generic only; if no Generic available, $0 Copay applies to Brand); biological sera, blood or blood plasma;
4. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
5. Charges for the administration or injection of any Drug;
6. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
7. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
8. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
9. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits.

A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges not shown as a Covered Prescription Drug in this Plan Document.

PRESCRIPTION DRUG UTILIZATION REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.