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	

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

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	

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

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**	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Wig (provided for hair loss during Chemotherapy/ Radiation Therapy)	80% of PPO rate Deductible applies	70% of Allowable Claim Limits Deductible applies	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**	80% of PPO rate Deductible	70% of Allowable Claim Limits Deductible applies	UR Notification required for Inpatient Hospice. For Homebound Hospice contact Utilization Review for Coordination of Care.
Bereavement Counseling	100% of PPO rate after $20 Copay Deductible waived	100% of Allowable Claim Limits $20 Copay Deductible waived	

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

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	
***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.

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.