SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE
SARASOTA MEMORIAL HEALTH CARE SYSTEM
HEALTH AND WELLNESS PLAN
GROUP NO. 18095

This Summary of Material Modification and Amendment describes changes to the Sarasota Memorial Health Care System Health and Wellness Plan effective October 1, 2021. These changes are effective as of **October 1, 2024** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

SMH Health Care, Inc. (the "Plan Sponsor") is amending the Sarasota Memorial Health Care System Health and Wellness Plan (the "Plan") as follows:

1. *Number (5) on the list of **Non-Participating Provider Exceptions** under **General Overview of the Plan** is hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Non-Participating Provider Exceptions

(5) Service not available at a SMH/GCPN provider but available with Aetna CP2 (with prior approval by medical management) will be considered at the SMH/GCPN tier level of benefits. Also, services not available at a SMH/GCPN or Aetna CP2 provider (with prior approval by medical management) will be considered at the SMH/GCPN tier level of benefits.

2. *In the **Medical Management Program** section of the Plan, number (6) under the **General Information** subsection and the first paragraph under the **Outpatient and Diagnostic Procedures Requiring Precertification** subsection are hereby deleted and replaced as shown below:*

MEDICAL MANAGEMENT PROGRAM

General Information

(6) Durable Medical Equipment (in excess of $1,000).

Outpatient and Diagnostic Procedures Requiring Precertification
Prior to undergoing any outpatient Surgery, invasive procedure, or office procedure over $2,000, a Covered Person or his/her attending Physician must request precertification from Gulf Coast Medical Management at www.gulfcoastmemberservices.org.

3. *For clarification purposes under the **Medical Management Program** section, all biopsies are included as part of the prenotification process, as such, breast and bone marrow biopsies will also be included as part of the Biopsies heading under **Recommended List of Items and/or Services for Prenotification**; and Biopsies (excluding skin) under prenotification is clarified to remove (excluding skin) from the heading.*

4. *The **Medical Schedule of Benefits – Basic Plan** is hereby deleted and replaced as shown in **Exhibit A**.*

5. *The **Prescription Drug Schedule of Benefits – Basic Plan** is hereby deleted and replaced as shown in **Exhibit B.***

6. *The **Medical Schedule of Benefits – Comprehensive Plan** is hereby deleted and replaced as shown in **Exhibit C.***

7. *The **Prescription Drug Schedule of Benefits – Comprehensive Plan** is hereby deleted and replaced as shown in **Exhibit D.***

8. *The **Medical Schedule of Benefits – Extended Plan** is hereby deleted and replaced as shown in **Exhibit E.***

9. *The **Prescription Drug Schedule of Benefits – Extended Plan** is hereby deleted and replaced as shown in **Exhibit F.***

10. *The **Employee Eligibility** subsection is hereby deleted and replaced and the **Acquisitions** subsection is hereby added under the **Eligibility for Participation** section as follows:*

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
Graduate Medical Education (GMA) Employees: A Full-Time, Part-Time or per diem Employee of the Employer who regularly works 20 or more Hours of Service per week or 40 or more Hours of Service per payroll will be eligible to enroll for coverage under this Plan as of the first day he/she reports for employment with the Employer. Includes Seasonal Employees. Participation in the Plan will begin as of the first day he or she reports for employment with the Employer provided all required election and enrollment forms are properly submitted to the Plan Administrator.

All Other Employees: A Full-Time, Part-Time or per diem Employee of the Employer who regularly works 20 or more Hours of Service per week or 40 or more Hours of Service per payroll will be eligible to enroll for coverage under this Plan as of the first day he/she reports for employment with the Employer. Includes Seasonal Employees. Participation in the Plan will begin as of the first day of the month following the date he or she reports for employment with the Employer provided all required election and enrollment forms are properly submitted to the Plan Administrator.

All Employees: You are not eligible to participate in the Plan if you are a temporary or leased employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Acquisitions
All eligible Employees (including eligible Dependents) of a company acquired by SMH Health Care, Inc.
are eligible for coverage under this Plan effective on the date of the acquisition, or the termination date of the prior company's coverage, whichever is later. All other provisions of this Plan will apply.

Any Deductible or Out-of-Pocket Maximum amounts satisfied with the previous employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's Deductible and Out-of-Pocket Maximum amounts as per the acquisitions agreement.

11. *Exclusion number **(75) – Surrogate** under **General Exclusions and Limitations** is hereby deleted and replaced with the following:*

GENERAL EXCLUSIONS AND LIMITATIONS

(75) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, SMH Health Care, Inc. has caused this Amendment to take effect, be attached to, and form a part of their Health and Wellness Plan.

Authorized Signature	9/3/24 Date	David Verinder President & Chief Executive Officer	Title
Witness	Date		Title

Reviewed by Legal Counsel and approved for signature S+B

EXHIBIT A

MEDICAL SCHEDULE OF BENEFITS – BASIC PLAN

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
LIFETIME MAXIMUM BENEFIT	Unlimited
PLAN YEAR MAXIMUM BENEFIT	Unlimited
PLAN YEAR DEDUCTIBLE Single Family	 $500 $1,000
TOTAL OVERALL PLAN YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)	
Single Family	$6,000 $12,000
MEDICAL BENEFITS	
Acupuncture	100%; Deductible waived
Plan Year Maximum Benefit Combined with Chiropractic Care and Holistic Care	15 visits or $600, whichever is less
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.	
Allergy Services	$35 Copay, then 100%; Deductible waived
Ambulance Services	$100 Copay, then 100%; Deductible waived
NOTE: Air ambulance services from a Non-Participating Provider for an Emergency Medical Condition will be paid at the SMH level of benefits.	
Breast Pumps	100%; Deductible waived
NOTE: Services from a Non-Participating Provider will be paid at the SMH level of benefits. Pumps in excess of $500 will require precertification. Includes any item or service not otherwise covered under the preventive services provision.	
Chemotherapy (Outpatient - includes all related charges)	$50 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)
Chiropractic Care/Spinal Manipulation	100%; Deductible waived
Plan Year Maximum Benefit Combined with Acupuncture and Holistic Care	15 visits or $600, whichever is less
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.	

Diagnostic Testing, X-Ray and Lab Services (Outpatient)	
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$100 Copay per visit, then 100%; Deductible waived
Bone Density	$35 Copay per visit, then 100%; Deductible waived
Endoscopy	$200 Copay per visit, then 100%; Deductible waived
Lab Services and Diagnostic Testing	$35 Copay per visit, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)
X-Ray	$35 Copay per visit, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)
NOTE: CPT code 81528 performed at Exact Sciences Laboratories (Tax ID# 46-3095174) will be paid at the SMH level of benefits. CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.	
Dialysis	$35 Copay, then 100%; Deductible waived
Durable Medical Equipment (DME)	85% after Deductible
Emergency Services/Emergency Room Services	$200 Copay, then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.	
Genetic Testing	$500 Copay per occurrence, then Deductible, then 85%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Hearing Aids (to age 18)	$100 Copay per pair of hearing aids, then 100%; Deductible waived
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years
Holistic Care (includes Herbal Medicine)	100%; Deductible waived
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less
Home Health Care	$35 Copay, then 100%; Deductible waived
Plan Year Maximum Benefit	60 visits
Hospice Care	100%; Deductible waived
Lifetime Maximum Benefit	60 days
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	Deductible, then $750 Copay per admission, then 100%
Room and Board Allowance*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible
Outpatient	
Surgery	Deductible, then $600 Copay per occurrence
Observation	Deductible, then $250 Copay per occurrence
Clinic	$35 Copay per occurrence, then 100%; Deductible waived
Miscellaneous Services & Supplies	85% 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.	

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Infusion Therapy (Outpatient)	$100 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)
Massage Therapy*	$35 Copay, then 100%; Deductible waived
Plan Year Maximum Benefit	30 visits
* Massage Therapy only covered at a Healthfit Powered by SMH location.	
Maternity (non-facility charges)*	
Preventive Prenatal	100%; Deductible waived
Breastfeeding Support (other than lactation consultations)**	100%; Deductible waived
Lactation Consultations	100%; Deductible waived
Initial Office Visit	$50 Copay, then 100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100%; Deductible waived
* See Preventive Services under Eligible Medical Expenses for limitations.	
** Services from a Non-Participating Provider will be paid at the SMH level of benefits. Breast pumps in excess of $500 will require precertification.	
Medical and Surgical Supplies	85% after Deductible
Mental Disorders and Substance Use Disorders	
Inpatient: Facility Charges Professional Fees	 Deductible, then $750 Copay per admission, then 100% 85% after Deductible
Outpatient: Office Visits Partial Hospitalization & Intensive Outpatient: SMHCS Facility All Other Providers All Other Outpatient Care	 100%; Deductible waived $35 Copay, then 100%; Deductible waived $60 Copay, then 100%; Deductible waived 100%; Deductible waived
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 (see Eligible Medical Expenses)	
Facility Charges	$2,500 Copay per admission, then 100%; Deductible waived
Professional Fees	$1,000 Copay per occurrence, then 100%; Deductible waived
Lifetime Maximum Benefit	1 Surgical Procedure
Nutritional Counseling	$35 Copay, then 100%; Deductible waived GCPN Select: Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Outpatient Therapies (physical, speech, occupational)	$35 Copay, then 100%; Deductible waived
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Physician's Services	
Inpatient/Outpatient Services	85% after Deductible
Office Visits: Primary Care Physician Specialist	$25 Copay*, then 100%; Deductible waived (No Copay applies only to the first Plan Year evaluation performed by MD, PA, or APRN) $50 Copay*, then 100%; Deductible waived
Physician Office Surgery	$50 Copay*, then 100%; Deductible waived
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.	
Pre-Admission Testing (Outpatient) SMHCS Facility All Other Providers	 100%; Deductible waived $35 Copay, then 100%; Deductible waived
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
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived
Radiation Therapy (Outpatient - includes all related charges)	$50 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)
Skilled Nursing Facility and Rehabilitation Facility	Deductible, then $750 Copay per admission, then 100%
Combined Plan Year Maximum Benefit	90 days (if not at SMHCS Facilities)
Sleep Disorders	$35 Copay, then 100%; Deductible waived
Sterilization (Vasectomy)	100%; Deductible waived
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%; Deductible waived
Lifetime Maximum Benefit	$1,000*
* Does not apply to diagnostic procedures and Surgical Procedures to treat conditions caused by a congenital or developmental deformity, disease or Injury.	

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Transplants	
Facility Charges	Deductible, then $750 Copay per admission, then 100%; Deductible waived (SMH and Aetna IOE Program)* Not Covered (All Other Aetna Providers)
Professional Fees	85% after Deductible (SMH and Aetna IOE Program)* Not Covered (All Other Aetna Providers)
* 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	$35 Copay*, then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered. Copay waived if sent to and treated in emergency room.	
NOTE: Services from an Aetna CPII Provider will be paid at the SMH level of benefits.	
Wellness & Educational Programs (through SMHCS only)	
Anticoagulation Clinic	100%; Deductible waived
Diabetes and Nutrition Program	100%; Deductible waived
Heart Failure Clinic	100%; Deductible waived
Lung Health Clinic	100%; Deductible waived
Secondary Stroke and TIA Prevention Clinic	100%; Deductible waived
Wig (see Eligible Medical Expenses)	$50 Copay, then 100%; Deductible waived
Maximum Benefit every 2 Years	$500
All Other Eligible Medical Expenses	85% after Deductible

EXHIBIT B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – BASIC PLAN

BENEFIT DESCRIPTION	SMHRXEXPRESS PHARMACY	PARTICIPATING PHARMACY
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider, except benefits will be reimbursed following the Copays shown below at a 30-day retail pharmacy only.		
BASIC PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance & Copays – combined with major medical Out-of-Pocket)		
Single	$6,000	
Family	$12,000	
Base Benefit*	$7,000	
*There is an annual limit on the portion of pharmacy costs paid by SMHCS as shown below. A pharmacy case manager is available to help Covered Persons in this Plan stay within the limits of the maximum expenses allowed. The limit will increase by an additional $1,500 for Covered Persons who work with a pharmacy case manager and their Physicians to consider appropriate medication substitutions.		
Additional Benefit if Pharmacy Case Management Utilized	$1,500	
Per Person Deductible (after Base Benefit and Additional Benefit amounts have been reached)	$1,000	
Coinsurance Amount After Per Person Deductible	50% (no per script maximum) 60% (with a pharmacy case manager) 80% (with a pharmacy case manager and chronic disease case manager)	
Retail Pharmacy: 30-day supply		
Generic Drug	$8 Copay	$9 Copay
Preferred Drug	40% Copay ($25 minimum per script; $100 maximum per script)	40% Copay ($25 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($35 minimum per script; $100 maximum per script)	60% Copay ($35 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Specialty Pharmacy Network: 30-day supply*		
Specialty Drug	$100 Copay	$100 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
*The Base Benefit, Additional Benefit, and Per Person Deductible amounts do not apply to Specialty Drugs.		

Copay Max Plus Program (provided by Navitus): The Plan works with the Copay Max Plus Program provided by Navitus to obtain copay assistance on your behalf. Coverage determinations for your requested drug must be directed to them. They may be contacted at (866) 333-2757 and will be able to address your questions. See section below for more information regarding this program.

BENEFIT DESCRIPTION	SMHRXEXPRESS PHARMACY	PARTICIPATING PHARMACY
Retail Pharmacy: 90-day supply		
Generic Drug	$16 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply		
Generic Drug	$20 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. 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.

Copay Max Plus Program (provided by Navitus)
The Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Copay Max Plus Program, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design.

Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the 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.

EXHIBIT C

MEDICAL SCHEDULE OF BENEFITS – COMPREHENSIVE PLAN

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
LIFETIME MAXIMUM BENEFIT	Unlimited
PLAN YEAR MAXIMUM BENEFIT	Unlimited
PLAN YEAR DEDUCTIBLE Single Family	 $0 $0
TOTAL OVERALL PLAN YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)	
Single Family	$4,000 $8,000
MEDICAL BENEFITS	
Acupuncture	100%
Plan Year Maximum Benefit Combined with Chiropractic Care and Holistic Care	15 visits or $600, whichever is less
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.	
Allergy Services	$35 Copay, then 100%
Ambulance Services	$100 Copay, then 100%
NOTE: Air ambulance services from a Non-Participating Provider for an Emergency Medical Condition will be paid at the SMH level of benefits.	
Breast Pumps	100%
NOTE: Services from a Non-Participating Provider will be paid at the SMH level of benefits. Pumps in excess of $500 will require precertification. Includes any item or service not otherwise covered under the preventive services provision.	
Chemotherapy (Outpatient - includes all related charges)	$50 Copay, then 100% (100% at SMHCS only)
Chiropractic Care/Spinal Manipulation	100%
Plan Year Maximum Benefit Combined with Acupuncture and Holistic Care	15 visits or $600, whichever is less
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.	

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$100 Copay per visit, then 100%
Bone Density	$35 Copay per visit, then 100%
Endoscopy	$200 Copay per visit, then 100%
Lab Services and Diagnostic Testing	$35 Copay per visit, then 100% (100% at SMHCS only)
X-Ray	$35 Copay per visit, then 100% (100% at SMHCS only)
NOTE: CPT code 81528 performed at Exact Sciences Laboratories (Tax ID# 46-3095174) will be paid at the SMH level of benefits. CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.	
Dialysis	$35 Copay, then 100%
Durable Medical Equipment (DME)	85%
Emergency Services/Emergency Room	$200 Copay, then 100%
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.	
Genetic Testing	$500 Copay per occurrence, then 85%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Hearing Aids (to age 18)	$100 Copay per pair of hearing aids, then 100%
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years
Holistic Care (includes Herbal Medicine)	100%
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less
Home Health Care	$35 Copay, then 100%
Plan Year Maximum Benefit	60 visits
Hospice Care	100%
Lifetime Maximum Benefit	60 days
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	$500 Copay per admission, then 100%
Room and Board Allowance*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100%
Outpatient	
Surgery	$350 Copay per occurrence, then 100%
Observation	$250 Copay per occurrence, then 100%
Clinic	$35 Copay per occurrence, then 100%
Miscellaneous Services & Supplies	85%
* 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.	
Infusion Therapy (Outpatient)	$100 Copay, then 100% (100% at SMHCS only)

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Massage Therapy*	$35 Copay, then 100% (SMHCS only)
Plan Year Maximum Benefit	30 visits
* Massage Therapy only covered at a Healthfit Powered by SMH location.	
Maternity (non-facility charges)*	
Preventive Prenatal	100%
Breastfeeding Support (other than lactation consultations)**	100%
Initial Office Visit	$50 Copay, then 100%
Lactation Consultations	100%
All Other Prenatal, Delivery and Postnatal Care	100%
* See Preventive Services under Eligible Medical Expenses for limitations.	
** Services from a Non-Participating Provider will be paid at the SMH level of benefits. Breast pumps in excess of $500 will require precertification.	
Medical and Surgical Supplies	85%
Mental Disorders and Substance Use Disorders	
Inpatient: Facility Charges Professional Fees	 $500 Copay per admission, then 100% 85%
Outpatient: Office Visits Partial Hospitalization & Intensive Outpatient All Other Outpatient Care	 100% $35 Copay, then 100% (100% at SMHCS only) 100%
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 (see Eligible Medical Expenses)	
Facility Charges	$2,500 Copay per admission, then 100%
Professional Fees	$1,000 Copay per occurrence, then 100%
Lifetime Maximum Benefit	1 Surgical Procedure
Nutritional Counseling	$35 Copay, then 100% GCPN Select: Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Outpatient Therapies (physical, speech, occupational)	$35 Copay, then 100%
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Physician's Services	
Inpatient/Outpatient Services	85%
Office Visits: Primary Care Physician Specialist	 100% $50 Copay*, then 100%
Physician Office Surgery	$50 Copay*, then 100%
*Copay applies to the Physician office visit component only. All other services are paid subject to any Coinsurance percentages.	
Pre-Admission Testing (Outpatient) SMHCS Facility All Other Providers	 100%; Deductible waived $35 Copay per visit, then 100%
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%
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%
Radiation Therapy (Outpatient - includes all related charges)	$50 Copay, then 100% (100% at SMHCS only)
Skilled Nursing Facility and Rehabilitation Facility	$500 Copay per admission, then 100%
Combined Plan Year Maximum Benefit	90 days (if not at SMHCS Facilities)
Sleep Disorders	$35 Copay, then 100%
Sterilization (Vasectomy)	100%
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%
Lifetime Maximum Benefit	$1,000*
* Does not apply to diagnostic procedures and Surgical Procedures to treat conditions caused by a congenital or developmental deformity, disease or Injury.	

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Transplants	
Facility Charges	$500 Copay per admission, then 100% (SMH and Aetna IOE Program)* Not Covered (All Other Aetna Providers)
Professional Fees	85% (SMH and Aetna IOE Program)* Not Covered (All Other Aetna Providers)
* 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%.	
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	$35 Copay*, then 100%
*Copay applies per visit regardless of what services are rendered. Copay waived if sent to and treated in emergency room.	
NOTE: Services from a Aetna CPII Provider will be paid at the SMH level of benefits.	
Wellness & Educational Programs (through SMHCS only)	
Anticoagulation Clinic	100%
Diabetes and Nutrition Program	100%
Heart Failure Clinic	100%
Lung Health Clinic	100%
Secondary Stroke and TIA Prevention Clinic	100%
Wig (see Eligible Medical Expenses)	$50 Copay, then 100%
Maximum Benefit every 2 Years	$500
All Other Eligible Medical Expenses	85%

EXHIBIT D

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – COMPREHENSIVE PLAN

BENEFIT DESCRIPTION	SMHRXEXPRESS PHARMACY	PARTICIPATING PHARMACY
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider, except benefits will be reimbursed following the Copays shown below at a 30-day retail pharmacy only.		
COMPREHENSIVE PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance & Copays – combined with major medical Out-of-Pocket)		
Single	$4,000	
Family	$8,000	
Base Benefit*	$7,000	
*There is an annual limit on the portion of pharmacy costs paid by SMHCS as shown below. A pharmacy case manager is available to help Covered Persons in this Plan stay within the limits of the maximum expenses allowed. The limit will increase by an additional $1,500 for Covered Persons who work with a pharmacy case manager and their Physicians to consider appropriate medication substitutions.		
Additional Benefit if Pharmacy Case Management Utilized	$1,500	
Per Person Deductible (after Base Benefit and Additional Benefit amounts have been reached)	$1,000	
Coinsurance Amount After Per Person Deductible	50% (no per script maximum) 60% (with a pharmacy case manager) 80% (with a pharmacy case manager and chronic disease case manager)	
Retail Pharmacy: 30-day supply		
Generic Drug	$8 Copay	$9 Copay
Preferred Drug	40% Copay ($25 minimum per script; $100 maximum per script)	40% Copay ($25 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($35 minimum per script; $100 maximum per script)	60% Copay ($35 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Specialty Pharmacy Network: 30-day supply*		
Specialty Drug	$100 Copay	$100 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
*The Base Benefit, Additional Benefit, and Per Person Deductible amounts do not apply to Specialty Drugs.		

BENEFIT DESCRIPTION	BENEFIT	
Retail Pharmacy: 90-day supply		
Generic Drug	$16 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply		
Generic Drug	$20 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Copay Max Plus Program (provided by Navitus): The Plan works with the Copay Max Plus Program provided by Navitus to obtain copay assistance on your behalf. Coverage determinations for your requested drug must be directed to them. They may be contacted at (866) 333-2757 and will be able to address your questions. See section below for more information regarding this program.		

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. 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.

Copay Max Plus Program (provided by Navitus)
The Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Copay Max Plus Program, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design.

Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the 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.

EXHIBIT E

MEDICAL SCHEDULE OF BENEFITS – EXTENDED PLAN

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		
PLAN YEAR MAXIMUM BENEFIT	Unlimited		
PLAN YEAR DEDUCTIBLE			
Single	$0	$1,500	$3,000
Family	$0	$4,500	$9,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)			
Single	$4,000	$5,000	Unlimited
Family	$8,000	$10,000	Unlimited
MEDICAL BENEFITS			
Acupuncture	100%	Paid at SMH level of benefits	Paid at SMH level of benefits
Plan Year Maximum Benefit Combined with Chiropractic Care and Holistic Care	15 visits or $600, whichever is less		
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.			
Allergy Services	$35 Copay, then 100%	70% after Deductible	40% after Deductible
Ambulance Services	$100 Copay, then 100%	Paid at SMH level of benefits	Paid at SMH level of benefits
Breast Pumps	100%	Paid at SMH level of benefits	Paid at SMH level of benefits
NOTE: Services from a Non-Participating Provider will be paid at the SMH level of benefits. Pumps in excess of $500 will require precertification. Includes any item or service not otherwise covered under the preventive services provision.			
Chemotherapy (Outpatient - includes all related charges)	$50 Copay, then 100% (100% at SMHCS only)	70% after Deductible	40% after Deductible
Chiropractic Care/Spinal Manipulation	100%	Paid at SMH level of benefits	Paid at SMH level of benefits
Plan Year Maximum Benefit Combined with Acupuncture and Holistic Care	15 visits or $600, whichever is less		
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the SMH Tier benefits.			

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$100 Copay per visit, then 100%	70% after Deductible	40% after Deductible
Bone Density	$35 Copay per visit, then 100%	70% after Deductible	40% after Deductible
Endoscopy	$200 Copay per visit, then 100%	70% after Deductible	40% after Deductible
Lab Services and Diagnostic Testing	$35 Copay per visit, then 100% (100% at SMHCS only)	70% after Deductible	40% after Deductible
X-Ray	$35 Copay per visit, then 100% (100% at SMHCS only)	70% after Deductible	40% after Deductible
NOTE: CPT code 81528 performed at Exact Sciences Laboratories (Tax ID# 46-3095174) will be paid at the SMH level of benefits. All other services will pay at the appropriate benefit level. CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.			
Dialysis	$35 Copay, then 100%	70% after Deductible	40% after Deductible
Durable Medical Equipment (DME)	85%	70% after Deductible	40% after Deductible
Emergency Services/Emergency Room	$250 Copay, then 100%	Paid at SMH level of benefits	Paid at SMH level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.			
Genetic Testing	$500 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Hearing Aids (to age 18)	$100 Copay per pair of hearing aids, then 100%	70% after Deductible	40% after Deductible
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years		
Holistic Care (includes Herbal Medicine)	100%	Paid at SMH level of benefits	Paid at SMH level of benefits
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less		
Home Health Care	$35 Copay, then 100%	70% after Deductible	40% after Deductible
Plan Year Maximum Benefit	60 visits		
Hospice Care	100%	70% after Deductible	40% after Deductible
Lifetime Maximum Benefit	60 days		

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$500 Copay per admission, then 100%	70% after Deductible	40% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care	ICU/CCU Room Rate	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100%	70% after Deductible	40% after Deductible
Outpatient			
Surgery	$350 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Observation	$250 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Clinic	$35 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Miscellaneous Services & Supplies	85%	70% after Deductible	40% 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.			
Infusion Therapy (Outpatient)	$100 Copay, then 100% (100% at SMHCS only)	70% after Deductible	40% after Deductible
Massage Therapy	$35 Copay, then 100% (SMHCS only)	Not Covered	Not Covered
Plan Year Maximum Benefit	30 visits		
NOTE: Massage Therapy only covered at a Healthfit Powered by SMH location			
Maternity (non-facility charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	100%; Deductible waived	40% after Deductible
Initial Office Visit	$50 Copay, then 100%	Deductible then, $50 Copay, then 70%	40% after Deductible
Lactation Consultations	100%	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100%	70% after Deductible	40% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	85% after Deductible	70% after Deductible	40% after Deductible

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Mental Disorders and Substance Use Disorders			
Inpatient:			
Facility Charges	$500 Copay per admission, then 100%	70% after Deductible	40% after Deductible
Professional Fees	85%	70% after Deductible	40% after Deductible
Outpatient:			
Office Visits	100%	$50 Copay, then 100%; Deductible waived (No Copay applies only to the first Plan Year evaluation performed by MD, PA, or APRN)	40% after Deductible
Partial Hospitalization & Intensive Outpatient	$35 Copay, then 100% (100% at SMHCS only)	$50 Copay	Not Covered
All Other Outpatient Care	100%	$50 Copay	40% 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 (see Eligible Medical Expenses)			
Facility Charges	$2,500 Copay per admission, then 100%	Deductible, then $2,500 Copay per procedure, then 70%	Deductible, then $2,500 Copay per procedure, then 40%
Professional Fees	$1,000 Copay per occurrence, then 100%	Deductible, then $1,000 Copay per procedure, then 70%	Deductible, then $1,000 Copay per procedure, then 40%
Lifetime Maximum Benefit	1 Surgical Procedure		
Nutritional Counseling	$35 Copay, then 100% GCPN Select: Not Covered	Not Covered	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Outpatient Therapies (physical, speech, occupational)	$35 Copay, then 100%	70% after Deductible	40% after Deductible
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)		

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services			
Inpatient/Outpatient Services	85%	70% after Deductible	40% after Deductible
Office Visits:			
Primary Care Physician	100%	$50 Copay*, then 100%; Deductible waived (No Copay applies only to the first Plan Year evaluation performed by MD, PA, or APRN)	40% after Deductible
Specialist	$50 Copay*, then 100%	$100 Copay*, then 100%; Deductible waived	40% after Deductible
Physician Office Surgery	$50 Copay*, then 100%	$100 Copay*, then 100%; Deductible waived	40% after Deductible
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.			
Pre-Admission Testing (Outpatient)			
SMHCS Facility	100%; Deductible waived	70% after Deductible	40% after Deductible
All Other Providers	$35 Copay per visit, then 100%	70% after Deductible	40% after Deductible
Preventive Services and Routine Care			
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%	100%; Deductible waived	40% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%	100%; Deductible waived	40% after Deductible
Radiation Therapy (Outpatient - includes all related charges)	$50 Copay, then 100% (100% at SMHCS only)	70% after Deductible	40% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	$500 Copay per admission, then 100%	70% after Deductible	40% after Deductible
Combined Plan Year Maximum Benefit	90 days (if not at SMHCS Facilities)		
Sleep Disorders	$35 Copay, then 100%	$50 Copay, then 100%; Deductible waived	40% after Deductible

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Sterilization (Vasectomy)	100%	100%; Deductible waived	40% after Deductible
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as PCP office visit benefits (no maximums or exclusions applied)	Paid same as PCP office visit benefits (no maximums or exclusions applied)	40% after Deductible
All Other Provider Services	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)	Paid same as PCP and Specialist office visit benefits (no maximums or exclusions applied)	Not Covered
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Lifetime Maximum Benefit	$1,000*		
* Does not apply to diagnostic procedures and Surgical Procedures to treat conditions caused by a congenital or developmental deformity, disease or Injury.			
Transplants			
Facility Charges	$500 Copay per admission, then 100%	$500 Copay per admission, then 100%; Deductible waived (SMH and Aetna IOE Program)* 40% after Deductible (All Other Network Providers)	40% after Deductible
Professional Fees	85% after Deductible	70% after Deductible	40% 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	$35 Copay*, then 100%	$35 Copay*, then 100%; Deductible waived	Deductible, then $35 Copay*, then 40%
*Copay applies per visit regardless of what services are rendered. Copay waived if sent to and treated in emergency room.			
Wellness & Educational Programs			
Anticoagulation Clinic	100%	70% after Deductible	40% after Deductible
Diabetes and Nutrition Program	100%	70% after Deductible	40% after Deductible
Heart Failure Clinic	100%	70% after Deductible	40% after Deductible
Lung Health Clinic	100%	70% after Deductible	40% after Deductible
Secondary Stroke and TIA Prevention Clinic	100%	70% after Deductible	40% after Deductible

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Wig (see Eligible Medical Expenses)	$50 Copay	70% after Deductible	40% after Deductible
Maximum Benefit every 2 Years	$500		
All Other Eligible Medical Expenses	*85%	70% after Deductible	40% after Deductible

EXHIBIT F

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – EXTENDED PLAN

BENEFIT DESCRIPTION	SMHRXEXPRESS PHARMACY	PARTICIPATING PHARMACY
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider, except benefits will be reimbursed following the Copays shown below at a 30-day retail pharmacy only.		
EXTENDED PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance & Copays – combined with major medical Out-of-Pocket)		
Single	$5,000	
Family	$10,000	
Base Benefit*	$7,000	
*There is an annual limit on the portion of pharmacy costs paid by SMHCS as shown below. A pharmacy case manager is available to help Covered Persons in this Plan stay within the limits of the maximum expenses allowed. The limit will increase by an additional $1,500 for Covered Persons who work with a pharmacy case manager and their Physicians to consider appropriate medication substitutions.		
Additional Benefit if Pharmacy Case Management Utilized	$1,500	
Per Person Deductible (after Base Benefit and Additional Benefit amounts have been reached)	$1,000	
Coinsurance Amount After Per Person Deductible	50% (no per script maximum) 60% (with a pharmacy case manager) 80% (with a pharmacy case manager and chronic disease case manager)	
Retail Pharmacy: 30-day supply		
Generic Drug	$8 Copay	$9 Copay
Preferred Drug	40% Copay ($25 minimum per script; $100 maximum per script)	40% Copay ($25 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($35 minimum per script; $100 maximum per script)	60% Copay ($35 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Specialty Pharmacy Network: 30-day supply*		
Specialty Drug	$100 Copay	$100 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
*The Base Benefit, Additional Benefit, and Per Person Deductible amounts do not apply to Specialty Drugs.		

Copay Max Plus Program (provided by Navitus): The Plan works with the Copay Max Plus Program provided by Navitus to obtain copay assistance on your behalf. Coverage determinations for your requested drug must be directed to them. They may be contacted at (866) 333-2757 and will be able to address your questions. See section below for more information regarding this program.

BENEFIT DESCRIPTION	SMHRXEXPRESS PHARMACY	PARTICIPATING PHARMACY
Retail Pharmacy: 90-day supply		
Generic Drug	$16 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply		
Generic Drug	$20 Copay	$20 Copay
Preferred Drug	40% Copay ($50 minimum per script; $100 maximum per script)	40% Copay ($50 minimum per script; $100 maximum per script)
Non-Preferred Drug	60% Copay ($75 minimum per script; $100 maximum per script)	60% Copay ($75 minimum per script; $100 maximum per script)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	$0 Copay (100% paid)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. 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.

Copay Max Plus Program (provided by Navitus)
The Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Copay Max Plus Program, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design.

Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the 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.