SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #7
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, 2026** 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. *The Meritain phone number on the **Cover Page** is hereby deleted in its entirety and not replaced.*

2. *Under the **General Overview of the Plan** section, the opening paragraphs and the **Integration of Deductibles and Out-of-Pocket Maximums** subsection are hereby deleted and replaced as shown below; In addition, the following **Non-Covered Facilities and Physicians – Basic Plan and Comprehensive Plan Only** subsection is hereby added as shown below:*

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement that provides access to one or more networks of Participating Providers called "Networks". Available Networks are identified on the Employee identification card. These Networks offer you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you.

If you are enrolled in the Basic Plan, there is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. You must seek care within the Network. Your Plan includes enhanced benefits when you receive care from smhCare preferred Tier 1 providers, as outlined in the Medical Schedule of Benefits. Expenses Incurred outside the Network will be denied, except as specified below.

If you are enrolled in the Comprehensive Plan or Extended Plan, there is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. Your Plan includes enhanced benefits when you receive care from smhCare preferred Tier 1 providers, as outlined in the Medical Schedule of Benefits.

You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

Non-Covered Facilities and Physicians – Basic Plan and Comprehensive Plan Only
For the Basic Plan and Comprehensive Plan – the following Facilities and Physicians are not considered in network and will only be covered for Emergency Medical Condition. Non Approved Aetna Providers except for Emergency Care:

(1) Advent Health Port Charlotte

(2) Baycare Hospital Manatee

(3) HCA FL Blake Hospital

(4) HCA FL Englewood Hospital

(5) HCA FL Fawcett Hospital

(6) HCA FL Sarasota Doctors Hospital

(7) Lakewood Ranch Medical Center

(8) Manatee Memorial Hospital

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers (e.g., Tier 1 and Tier 2), your total Deductible amount and Out-of-Pocket Maximum amount required to be paid are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Participating Providers (e.g., Tier 1 and Tier 2) and Non-Participating Providers separately.

All other maximum amounts (e.g., Plan Year or Lifetime) are combined.

3. *The **Quantum Health** section of the Plan is hereby added to the Plan after the **General Overview of the Plan** section as shown in **Exhibit A.***

4. *Under the **Medical Management Program** section, the **General Information** subsection is hereby deleted and replaced as shown below; In addition, the **Outpatient and Diagnostic Procedures Requiring Precertification** subsection is hereby deleted in its entirety and not replaced.*

MEDICAL MANAGEMENT PROGRAM

General Information
All non-emergency office procedures greater than $2,400 require pre-authorization and must be done at an SMHCS facility if clinically appropriate.

You are responsible to ensure that you or your provider obtains precertification for all:

(1) Inpatient Hospital admissions (except SMHCS emergent admissions or SMHCS IRF admission).

(2) Skilled Nursing Facility Admissions (Inpatient). (Except at SMHCS Facilities)

(3) Hospice Care (Inpatient only)

(4) Organ, Tissue, and Bone Marrow Transplants (Evaluation, Inpatient, or Outpatient)

(5) Outpatient Surgeries provided in a Hospital/ASC Setting (Outpatient) (Except Colonoscopies at SMHCS Facilities)

(6) Physician office Surgeries billed over $2,400

(7) Home Health Care (Outpatient)

(8) Diagnostics MRI/MRA/PET (Outpatient) (Except at SMHCS Facilities)

(9) Genetic Testing (Outpatient)

(10) Oncology Services – Chemotherapy, Radiation and Clinical Trials (Outpatient) (Except at SMHCS Facilities)

(11) Infusion Centers, Home Infusion, or Office Infusion for billed over $1,000. (Except at SMHCS Facilities)

(12) Bariatric Services (Outpatient or Inpatient)

(13) Durable Medical Equipment over $1,500 and all rentals (Outpatient)

(14) Mental Disorders and Substance Use Disorders (Inpatient, PHP, IOP, Residential). Except for Inpatient, Partial Hospitalization, and Intensive Outpatient at SMHCS Facilities.

(15) Advanced Behavioral Health Therapies (ECT, TMS, and related therapies). Except at SMHCS Facilities.

Failure to obtain precertification for the above services will result in reduced benefits. To obtain precertification, you must work with the provider to place authorization at www.gulfcoastmemberservices.org.

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

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

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

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

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

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

11. *Under the **Eligible Medical Expenses** section, numbers **(4) – Ambulatory Surgical Center**, **(37) – Mental Disorders** and the provision for **Transplants (Cornea Only – applies to Basic and Comprehensive plans only)** that was added in Amendment #3 are hereby deleted and replaced as shown below; In addition, number **(65) - Transplants (other than those received through the Aetna IOE Program- applies to Extended Plan only)** is hereby deleted in its entirety and not replaced.*

ELIGIBLE MEDICAL EXPENSES

(4) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(37) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism (including applied behavioral analysis), ADD and ADHD and family counseling. Services provided in the home or school setting by an in-network Board Certified Behavioral Analyst (BCBA) will be allowed. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(#) **Transplants (Cornea Only):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational cornea transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) Lodging expenses, including meals.

(c) Expenses related to the Covered Person's travel.

(d) The purchase price of any organ, tissue or any similar items which are sold rather than donated.

(e) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

12. *Item **(A)** under number **(iv) - Prevention for Women** under letter **(a) – Preventive Services** under number **(49) – Preventive Services and Routine Care** under the **Eligible Medical Expenses** section is hereby deleted and replaced as shown below:*

ELIGIBLE MEDICAL EXPENSES

(49) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(iv) Prevention for Women

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

For the period of time in which the Department of Health and Human Services (HHS) allows a "maternity global rate" and a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. This provision will no longer apply once "maternity global rates" are no longer permissible according to coding regulations per Department of Health and Human Services (HHS) guidelines.

13. *Number **(45) - Non-Participating Provider Services (Basic Plan & Comprehensive Plan)** and the **Transplants (Basic and Comprehensive Plans only)** exclusion that was added in Amendment #3 under the **General Exclusions and Limitations** section are hereby deleted and replaced as shown below:*

GENERAL EXCLUSIONS AND LIMITATIONS

(45) **Non-Participating Provider Services (Basic Plan only)**: Expenses for services received by a Non-Participating Provider will not be considered eligible, except as specified under the General Overview of the Plan section.

(#) **Transplants:** Expenses for transplants performed outside the Aetna Institute of Excellence (IOE) Program and Tier 1 Providers will not be considered eligible, except for cornea transplants as specified under Eligible Medical Expenses. Please refer to the Aetna Institute of Excellence (IOE) Program section.

14. *The **Prescription Drug Program** section is hereby deleted and replaced as shown in **Exhibit H**.*

15. *The **Timely Filing** subsection under the **Claim Procedures** section is hereby deleted and replaced as shown below:*

CLAIM PROCEDURES

Timely Filing
All claims must be filed with the Third Party Administrator within 180 days following the date services were Incurred. Claims filed after this time period will be denied.

16. *Under the **General Plan Information** section, the **Third Party Administrator** and **Prescription Drug Program Administrator** subsections are hereby deleted and replaced as shown below; In addition, the following **Customer Service** subsection is hereby added after the **Third Party Administrator** subsection as shown below:*

GENERAL PLAN INFORMATION

Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921
Customer Service	Quantum Health 5240 Blazer Parkway Dublin, OH 43017 (844) 573-1532 Mysmhcarehub.com
Prescription Drug Program Administrator:	RxBenefits (844) 573-1532 Mysmhcarehub.com

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.

For David Verinder
President & Chief Executive Officer

Authorized Signature Date

Title

Witness Date

Title

18095-07

Reviewed by
Cari Campbell, Esq., Legal Counsel
and approved for signature

EXHIBIT A

QUANTUM HEALTH

To best assist covered individuals with navigation of the healthcare system, the Plan includes services provided by Quantum Health. These services are intended to help Members better understand their available health and welfare benefits. Quantum Health services are available to Covered Members and their providers for information, help, and guidance, and can be reached toll-free by calling Quantum Health at **1-844-573-1532.**

Quantum Health's Services

Quantum Health provides a single point of contact through Customer Care Coordinators (also referred to as Patient Service Representatives) for Members and providers to help with Member navigation through their individual healthcare journey, including, but not limited to:

- Answering questions about eligibility, Plan benefits and coverage levels,
- Locating providers based on network status and individual Member needs,
- Outreaching to Members and educating them about the benefits of using in-network providers and other resources available under the Plan,
- Identifying and educating Members about availability of community resources,
- Advising on Claim and appeal status, how-to-understand explanations of benefits ("EOBs") and health care bills, and
- Other general customer service functions on behalf of the Plan.

If you have any questions about your benefits under the Plan, you should reach out to Quantum Health at 1-844-573-1532

The Member's Role

Members play a vital role in this process. To maximize benefits available under the Plan, you should familiarize yourself with and follow the processes outlined below and any other applicable Plan provisions. **Please note that failure to comply with requirements under the Plan can result in significant benefit reductions, which may include penalties, higher co-payments and cost-sharing, balance billing or denials of coverage for certain services. When in doubt, contact Quantum Health at 1-844-573-1532.**

Use In-Network Providers where Possible to Reduce Your Out-of-Pocket Costs.

The Plan offers a broad network of providers and the benefits under the Plan are more generous when a Member receives services from a participating provider (aka, "in-network"). **To find in-network providers, please visit the Plan's website at mysmhcarehub.com or call Quantum Health at 1-844-573-1532.** The Schedule of Benefits provided in the SPD and in the Summary of Benefits and Coverage ("SBC") provided by the Plan identifies the coverage differences between services provided in-network and out-of-network. Generally, receiving services from out-of-network providers will result in increased Member financial responsibility and could result in balance billing by the provider for many non-emergency services as otherwise explained in the SPD.

EXHIBIT B

MEDICAL SCHEDULE OF BENEFITS – BASIC PLAN

BASIC PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	$500	$2,500
Family	$1,000	$7,500
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$2,600	$8,000
Family	$5,200	$16,000
MEDICAL BENEFITS		
Acupuncture	100%; Deductible waived	Paid at smhCare 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 smhCare Tier benefits.		
Allergy Services	$45 Copay, then 100%; Deductible waived	60%; Deductible waived
Ambulance Services		
Air	$300 Copay, then 100%; Deductible waived	$300 Copay, then 100%; Deductible waived
All Other Services	$150 Copay, then 100%; Deductible waived	$150 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.		
Ambulatory Surgical Center	$250 Copay, then 100%; Deductible waived	$800 Copay, then 100%; Deductible waived
Breast Pumps	100%; Deductible waived	Paid at smhCare level of benefits
NOTE: Services from a Non-Participating Provider will be paid at the smhCare 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)		
Hospital	$125 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)	$175 Copay, then 100%; Deductible waived

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
Office/non-Hospital	$125 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)	$150 Copay, then 100%; Deductible waived
Chiropractic Care/Spinal Manipulation	100%; Deductible waived	Paid at smhCare 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 smhCare Tier benefits.		
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$60 Copay per visit, then 100%; Deductible waived (Only allowed at SMH or ACH)	$450 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($900 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)
Bone Density	$35 Copay per visit, then 100%; Deductible waived (SMH, ACH, SMH Med Staff or ACH Office)	$150 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($300 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)
Endoscopy	$45 Copay per visit, then 100%; Deductible waived (Only allowed at SMH or ACH)	$450 Copay per visit, then 100%; Deductible waived (Non-Hospital) $925 Copay, then 100%; Deductible waived (On/Off Campus Hospital)
Diagnostic Testing and Lab Services	$35 Copay per visit, then 100%; Deductible waived (SMH, ACH, SMH Med Staff or ACH Office)	$150 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($300 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)
X-Ray	$35 Copay per visit, then 100%; Deductible waived (SMH, ACH, SMH Med Staff or ACH Office)	$150 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($300 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)
Physician's Services Diagnostic Imaging Endoscopy	 100%; Deductible waived 85%; Deductible waived	 60%; Deductible waived 60%; Deductible waived
NOTE: CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.		
Dialysis	$40 Copay, then 100%; Deductible waived	$40 Copay, then 100%; Deductible waived
Durable Medical Equipment (DME)	85% after Deductible	60% after Deductible

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
Emergency Services/Emergency Room	$300 Copay, then 100%; Deductible waived (100%; Deductible waived for Physician's Services)	Paid at smhCare level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Genetic Testing	85%; Deductible waived	$300 Copay per occurrence, then 100%; Deductible waived
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	60% after Deductible
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years	
Holistic Care (includes Herbal Medicine)	100%; Deductible waived	Paid at smhCare level of benefits
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less	
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the smhCare Tier benefits.		
Home Health Care	$35 Copay, then 100%; Deductible waived	$70 Copay, then 100%; Deductible waived
Plan Year Maximum Benefit	60 visits	
Hospice Care	100%; Deductible waived	60% after Deductible
Lifetime Maximum Benefit	60 days	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	$300 Copay per admission, then 100%; Deductible waived	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	85%; Deductible waived	60% after Deductible
Outpatient		
Surgery	$200 Copay per occurrence, then 100%; Deductible waived	60% after Deductible
Observation	$200 Copay per occurrence, then 100%; Deductible waived	60% after Deductible
Clinic	$35 Copay, then 100%; Deductible waived	60% after Deductible
Miscellaneous Services & Supplies	85%; Deductible waived	60% 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.		

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
Infusion Therapy (Outpatient)		
Hospital	$125 Copay, then 100%; Deductible waived (100%; Deductible waived at SMHCS only)	$175 Copay, then 100%; Deductible waived
Office/non-Hospital	$125 Copay, then 100%; Deductible waived	$150 Copay, then 100%; Deductible waived
Massage Therapy	$30 Copay, then 100%; Deductible waived (SMHCS only)	Not Covered
Plan Year Maximum Benefit	30 visits	
NOTE: Massage Therapy only covered at a Healthfit Powered by SMH locations.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	100%; Deductible waived
Office Visit	$40 Copay, then 100%; Deductible waived (initial office visit) (100%; Deductible waived all other visits)	$70 Copay, then 100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100%; Deductible waived	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical and Surgical Supplies	85% after Deductible	60% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient Mental Disorders: Facility Charges Professional Fees	$300 Copay per admission, then 100%; Deductible waived 85%; Deductible waived	60% after Deductible 60%; Deductible waived
Inpatient Substance Use Disorders: Facility Charges Professional Fees	$300 Copay per admission, then 100%; Deductible waived 85%; Deductible waived	$300 Copay per admission, then 100%; Deductible waived 60%; Deductible waived
Inpatient Residential Treatment Center Facility Charges Professional Fees	$300 Copay per admission, then 100%; Deductible waived 85%; Deductible waived	$300 Copay per admission, then 100%; Deductible waived 60%; Deductible waived
Plan Year Maximum Benefit	180 days	
Outpatient: Office Visits Applied Behavioral Analysis Partial Hospitalization & Intensive Outpatient	$15 Copay, then 100%; Deductible waived $20 Copay, then 100%; Deductible waived $35 Copay, then 100%; Deductible waived	$40 Copay, then 100%; Deductible waived $25 Copay, then 100%; Deductible waived $50 Copay, then 100%; Deductible waived

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
All Other Outpatient Care	$35 Copay, then 100%; Deductible waived	60%; Deductible waived
NOTE: Any visit maximums regarding home health care and outpatient therapies (as applicable) will not apply to Mental Disorders or Substance Use Disorders.		
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	Paid at smhCare level of benefits
Professional Fees	$1,000 Copay per occurrence, then 100%; Deductible waived	Paid at smhCare level of benefits
Lifetime Maximum Benefit	1 Surgical Procedure	
NOTE: Morbid Obesity is only covered at Tampa General Hospital.		
Nutritional Counseling		
Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder	100%; Deductible waived (Only allowed at SMH or ACH)	$40 Copay, then 100%; Deductible waived
All Other Nutritional Counseling	$35 Copay, then 100%; Deductible waived (Only allowed at SMH or ACH)	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Outpatient Therapies (physical, speech, occupational)	$30 Copay, then 100%; Deductible waived (Only allowed at SMH or ACH)	$125 Copay, then 100%; Deductible waived (Non-Facility) ($250 Copay, then 100%; Deductible waived (Facility))*
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)	
*NOTE: Covered Persons under the age of 18 will be covered at the smhCare Tier 1 level of benefits.		
Physician's Services		
Inpatient/Outpatient Services	85%; Deductible waived	60%; Deductible waived
Office Visits: Primary Care Physician Specialist	$15 Copay*, then 100%; Deductible waived $35 Copay*, then 100%; Deductible waived	$40 Copay*, then 100%; Deductible waived $70 Copay*, then 100%; Deductible waived
Physician Office Surgery	$50 Copay*, then 100%; Deductible waived	60%; 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)	$35 Copay, then 100%; Deductible waived (SMH and ACH Only)	60% after Deductible

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
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%; Deductible waived	100%; Deductible waived
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	100%; Deductible waived
Radiation Therapy (Outpatient - includes all related charges)		
Hospital	$125 Copay, then 100%; Deductible waived (SMH and ACH Only) (100%; Deductible waived at SMHCS only)	$175 Copay, then 100%; Deductible waived
Office/non-Hospital	Not Applicable	$150 Copay, then 100%; Deductible waived
Skilled Nursing Facility and Rehabilitation Facility	$300 Copay per admission, then 100%; Deductible waived	$200 Copay per day, then 100%; Deductible waived (up to 10 days) 100%; Deductible waived (days 10-180)
Combined Plan Year Maximum Benefit	180 days (if not at SMHCS Facilities)	
Sleep Disorders	$35 Copay, then 100%; Deductible waived	60% after Deductible
Sterilization (Vasectomy)	100%; Deductible waived	100%; Deductible waived
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.		
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%; Deductible waived	$500 Copay per occurrence, then 60%; 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.		

BASIC PLAN	TIER 1: **smhCare PREFERRED PROVIDERS** (For Services Offered and/or Rendered)	TIER 2: **AETNA CPII PROVIDERS**
Transplants		
Facility Charges	$300 Copay per admission, then 100%; Deductible waived	Paid at smhCare level of benefits (Aetna IOE Program)* Not Covered (All Other Network Providers)
Professional Fees	85%; Deductible waived	Paid at smhCare level of benefits
* 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	$30 Copay*, then 100%; Deductible waived	$75 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.		
Wellness & Educational Programs		
Anticoagulation Clinic	100%; Deductible waived	Not Covered
Diabetes and Nutrition Program	100%; Deductible waived	Not Covered
Heart Failure Clinic	100%; Deductible waived	Not Covered
Lung Health Clinic	100%; Deductible waived	Not Covered
Secondary Stroke and TIA Prevention Clinic	100%; Deductible waived	Not Covered
Wig (see Eligible Medical Expenses)	$50 Copay, then 100%; Deductible waived	$50 Copay, then 100%; Deductible waived
Maximum Benefit every 2 Years	$500	
All Other Eligible Medical Expenses	85%; Deductible waived	65% after Deductible

EXHIBIT C

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.		
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) Single Family	$8,000 $16,000	
Retail Pharmacy: 30-day supply		
Generic Drug	$10 Copay	$12 Copay
Preferred Drug	$40 Copay	$40 Copay
Non-Preferred Drug	$70 Copay	$70 Copay
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	$125 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
Retail Pharmacy: 90-day supply		
Generic Drug	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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.

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 D

MEDICAL SCHEDULE OF BENEFITS – COMPREHENSIVE PLAN

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (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	$2,000	$3,500
Family	$0	$6,000	$10,500
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)			
Single	$2,000	$8,000	Unlimited
Family	$4,000	$16,000	Unlimited
MEDICAL BENEFITS			
Acupuncture	100%	Paid at smhCare level of benefits	Paid at smhCare 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 smhCare Tier benefits.			
Allergy Services	$35 Copay, then 100%	65%; Deductible waived	40% after Deductible
Ambulance Services			
Air	$250 Copay, then 100%	$250 Copay, then 100%; Deductible waived	$250 Copay, then 100%; Deductible waived
All Other Services	$125 Copay, then 100%	$125 Copay, then 100%; Deductible waived	$125 Copay, then 100%; Deductible waived
Ambulatory Surgical Center	$200 Copay, then 100%	$700 Copay, then 100%; Deductible waived	40% after Deductible
Breast Pumps	100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
NOTE: Services from a Non-Participating Provider will be paid at the smhCare 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)			
Hospital	$100 Copay, then 100% (100% at SMHCS only)	$175 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	$100 Copay, then 100% (100% at SMHCS only)	$150 Copay, then 100%; Deductible waived	40% after Deductible

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chiropractic Care/Spinal Manipulation	100%	Paid at smhCare level of benefits	Paid at smhCare 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 smhCare Tier benefits.			
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$50 Copay per visit, then 100% (Only allowed at SMH or ACH)	$375 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($750 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Bone Density	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$125 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($250 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Endoscopy	$45 Copay per visit, then 100% (Only allowed at SMH or ACH)	$375 Copay per visit, then 100%; Deductible waived (Non-Hospital) $750 Copay, then 100%; Deductible waived (On/Off Campus Hospital	40% after Deductible
Diagnostic Testing and Lab Services	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$125 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($250 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
X-Ray	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$125 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($250 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Physician's Services Diagnostic Imaging Endoscopy	 100% 90%	 65%; Deductible waived 65%; Deductible waived	 40% after Deductible 40% after Deductible
NOTE: CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.			
Dialysis	$35 Copay, then 100%	$35 Copay, then 100%; Deductible waived	40% after Deductible

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	90%	65%; Deductible waived	40% after Deductible
Emergency Services/Emergency Room	$250 Copay, then 100% (100% for Physician's Services)	Paid at smhCare level of benefits	Paid at smhCare level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.			
Genetic Testing	90%	$300 Copay per occurrence, then 100%; Deductible waived	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%	65% after Deductible	Not Covered
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years		
Holistic Care (includes Herbal Medicine)	100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less		
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the smhCare Tier benefits.			
Home Health Care	$35 Copay, then 100%	$70 Copay, then 100%; Deductible waived	40% after Deductible
Plan Year Maximum Benefit	60 visits		
Hospice Care	100%	65% after Deductible	40% after Deductible
Lifetime Maximum Benefit	60 days		
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$250 Copay per admission, then 100%	65% after Deductible	40% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*	Semi-PrivateRoom Rate*
Intensive Care	ICU/CCU Room Rate	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	90%	65% after Deductible	40% after Deductible
Outpatient			
Surgery	$150 Copay per occurrence, then 100%	65% after Deductible	40% after Deductible
Observation	$150 Copay per occurrence, then 100%	65% after Deductible	40% after Deductible
Clinic	100%	65% after Deductible	40% after Deductible
Miscellaneous Services & Supplies	90%	65% 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.			

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Infusion Therapy (Outpatient)			
Hospital	$100 Copay, then 100% (100% at SMHCS only)	$175 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	$100 Copay, then 100% (100% at SMHCS only)	$150 Copay, then 100%; Deductible waived	40% after Deductible
Massage Therapy	$25 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 locations.			
Maternity (non-facility charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	100%; Deductible waived	40% after Deductible
Office Visit	$35 Copay, then 100%(initial office visit) (100% all other visits)	$55 Copay, then 100%; Deductible waived	40% after Deductible
Lactation Consultations	100%	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100%	65% after Deductible	40% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.			
Medical and Surgical Supplies	90%	65%; Deductible waived	40% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient Mental Disorders:			
Facility Charges	$250 Copay per admission, then 100%	65% after Deductible	40% after Deductible
Professional Fees	90%	65%; Deductible waived	40% after Deductible
Inpatient Substance Use Disorders:			
Facility Charges	$250 Copay per admission, then 100%	$250 Copay per admission, then 100%; Deductible waived	40% after Deductible
Professional Fees	90%	65%; Deductible waived	40% after Deductible
Inpatient Residential Treatment Center			
Facility Charges	$250 Copay per admission, then 100%	$250 Copay per admission, then 100%; Deductible waived	Not Covered
Professional Fees	90%	65%; Deductible waived	Not Covered
Plan Year Maximum Benefit	180 days		
Outpatient:			
Office Visits	$10 Copay, then 100%	$30 Copay, then 100%; Deductible waived	40% after Deductible
Applied Behavioral Analysis	$15 Copay, then 100%	$20 Copay, then 100%; Deductible waived	40% after Deductible
Partial Hospitalization & Intensive Outpatient	100%	$40 Copay, then 100%; Deductible waived	Not Covered
All Other Outpatient Care	100%	65%; Deductible waived	40% after Deductible

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
NOTE: Any visit maximums regarding home health care and outpatient therapies (as applicable) will not apply to Mental Disorders or Substance Use Disorders.			
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%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Professional Fees	$1,000 Copay per occurrence, then 100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Lifetime Maximum Benefit	1 Surgical Procedure		
NOTE: Morbid Obesity is only covered at Tampa General Hospital.			
Nutritional Counseling			
Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder	100% (Only allowed at SMH or ACH)	$30 Copay, then 100%; Deductible waived	40% after Deductible
All Other Nutritional Counseling	$35 Copay, then 100% (Only allowed at SMH or ACH)	Not Covered	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Outpatient Therapies (physical, speech, occupational)	$25 Copay, then 100% (Only allowed at SMH or ACH)	$100 Copay, then 100%; Deductible waived (Non-Facility) ($200 Copay, then 100%; Deductible waived (Facility))*	40% after Deductible
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)		
*NOTE: Covered Persons under the age of 18 will be covered at the smhCare Tier 1 level of benefits.			
Physician's Services			
Inpatient/Outpatient Services	90%	65%; Deductible waived	40% after Deductible
Office Visits:			
Primary Care Physician	$10 Copay*, then 100%	$30 Copay*, then 100%; Deductible waived	40% after Deductible
Specialist	$35 Copay*, then 100%	$55 Copay*, then 100%; Deductible waived	40% after Deductible
Physician Office Surgery	$50 Copay*, then 100%	65%; 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)	100% (SMH and ACH Only)	65% after Deductible	40% after Deductible

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
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)			
Hospital	$100 Copay, then 100% (SMH and ACH Only) (100% at SMHCS only)	$175 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	Not Applicable	$150 Copay, then 100%; Deductible waived	40% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	$250 Copay per admission, then 100%	$200 Copay per day, then 100%; Deductible waived (up to 10 days) 100%; Deductible waived (days 10-180)	Not Covered
Combined Plan Year Maximum Benefit	180 days (if not at SMHCS Facilities)		
Sleep Disorders	$35 Copay, then 100%	65% after Deductible	40% after Deductible
Sterilization (Vasectomy)	100%	100%; Deductible waived	40% after Deductible
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.			
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

COMPREHENSIVE PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%	65% after Deductible	Deductible, then $500 Copay per occurrence, then 40%
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	$250 Copay per admission, then 100%	Paid at smhCare level of benefits (smhCare and Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
Professional Fees	90%	Paid at smhCare level of benefits (smhCare and Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* 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	$25 Copay*, then 100%	$60 Copay*, then 100%; Deductible waived	Deductible, then $120 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%	Not Covered	Not Covered
Diabetes and Nutrition Program	100%	Not Covered	Not Covered
Heart Failure Clinic	100%	Not Covered	Not Covered
Lung Health Clinic	100%	Not Covered	Not Covered
Secondary Stroke and TIA Prevention Clinic	100%	Not Covered	Not Covered
Wig (see Eligible Medical Expenses)	$50 Copay	$50 Copay, then 100%; Deductible waived	$50 Copay, then 100%; Deductible waived
Maximum Benefit every 2 Years	$500		
All Other Eligible Medical Expenses	90%	65% after Deductible	40% after Deductible

EXHIBIT E

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.		
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) Single Family	$8,000 $16,000	
Retail Pharmacy: 30-day supply		
Generic Drug	$10 Copay	$12 Copay
Preferred Drug	$40 Copay	$40 Copay
Non-Preferred Drug	$70 Copay	$70 Copay
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	$125 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
Retail Pharmacy: 90-day supply		
Generic Drug	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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.

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 F

MEDICAL SCHEDULE OF BENEFITS – EXTENDED PLAN

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (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	$2,000	$6,000	Unlimited
Family	$4,000	$12,000	Unlimited
MEDICAL BENEFITS			
Acupuncture	100%	Paid at smhCare level of benefits	Paid at smhCare 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 smhCare Tier benefits.			
Allergy Services	$35 Copay, then 100%	70%; Deductible waived	40% after Deductible
Ambulance Services			
Air	$250 Copay, then 100%	$250 Copay, then 100%; Deductible waived	$250 Copay, then 100%; Deductible waived
All Other Services	$125 Copay, then 100%	$125 Copay, then 100%; Deductible waived	$125 Copay, then 100%; Deductible waived
Ambulatory Surgical Center	$200 Copay, then 100%	$350 Copay, then 100%; Deductible waived	40% after Deductible
Breast Pumps	100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
NOTE: Services from a Non-Participating Provider will be paid at the smhCare 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)			
Hospital	$100 Copay, then 100% (100% at SMHCS only)	$150 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	$100 Copay, then 100% (100% at SMHCS only)	$125 Copay, then 100%; Deductible waived	40% after Deductible

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chiropractic Care/Spinal Manipulation	100%	Paid at smhCare level of benefits	Paid at smhCare 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 smhCare Tier benefits.			
Diagnostic Testing, X-Ray and Lab Services (Outpatient)			
Advanced Imaging (MRI, MRA, CT and PET Scans, Scintimammography, Nuclear Medicine)	$50 Copay per visit, then 100% (Only allowed at SMH or ACH)	$150 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($300 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Bone Density	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$50 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($100 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Endoscopy	$45 Copay per visit, then 100% (Only allowed at SMH or ACH)	$150 Copay per visit, then 100%; Deductible waived (Non-Hospital) $300 Copay, then 100%; Deductible waived (On/Off Campus Hospital	40% after Deductible
Diagnostic Testing and Lab Services	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$50 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($100 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
X-Ray	$35 Copay per visit, then 100% SMH Med Staff or ACH Office (100% at SMH and ACH only)	$50 Copay, then 100%; Deductible waived (Office or Freestanding Facility) ($100 Copay, then 100%; Deductible waived (On-Campus or Off-Campus Outpatient Hospital)	40% after Deductible
Physician's Services Diagnostic Imaging Endoscopy	 100% 90%	 70%; Deductible waived 70%; Deductible waived	 40% after Deductible 40% after Deductible
NOTE: CPT code 75571 is covered at SMHCS only and will be paid at $35 Copay.			
Dialysis	$35 Copay, then 100%	$35 Copay, then 100%; Deductible waived	40% after Deductible

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	90%	70%; Deductible waived	40% after Deductible
Emergency Services/Emergency Room	$250 Copay, then 100% (100% for Physician's Services)	Paid at smhCare level of benefits	Paid at smhCare level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.			
Genetic Testing	90%	$300 Copay per occurrence, then 100%; Deductible waived	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	Not Covered
Maximum Benefit	$2,600 per Plan Year and 1 pair of hearing aids every 3 years		
Holistic Care (includes Herbal Medicine)	100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Plan Year Maximum Benefit Combined with Acupuncture and Chiropractic Care	15 visits or $600, whichever is less		
NOTE: Services performed by a CP2 or Non-Participating Provider are covered without approval under the smhCare Tier benefits.			
Home Health Care	$35 Copay, then 100%	$50 Copay, then 100%; Deductible waived	40% after Deductible
Plan Year Maximum Benefit	60 visits		
Hospice Care	100%	70% after Deductible	40% after Deductible
Lifetime Maximum Benefit	60 days		
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)			
Inpatient	$250 Copay per admission, then 100%	70% after Deductible	40% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*	Semi-PrivateRoom Rate*
Intensive Care	ICU/CCU Room Rate	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	90%	70% after Deductible	40% after Deductible
Outpatient			
Surgery	$150 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Observation	$150 Copay per occurrence, then 100%	70% after Deductible	40% after Deductible
Clinic	100%	70% after Deductible	40% after Deductible
Miscellaneous Services & Supplies	90%	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.			

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Infusion Therapy (Outpatient)			
Hospital	$100 Copay, then 100% (100% at SMHCS only)	$150 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	$100 Copay, then 100% (100% at SMHCS only)	$125 Copay, then 100%; Deductible waived	40% after Deductible
Massage Therapy	$25 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 locations.			
Maternity (non-facility charges)*			
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	100%; Deductible waived	40% after Deductible
Office Visit	$35 Copay, then 100%(initial office visit) (100% all other visits)	$55 Copay, then 100%; Deductible waived	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	90%	70%; Deductible waived	40% after Deductible
Mental Disorders and Substance Use Disorders			
Inpatient Mental Disorders:			
Facility Charges	$250 Copay per admission, then 100%	70% after Deductible	40% after Deductible
Professional Fees	90%	70%; Deductible waived	40% after Deductible
Inpatient Substance Use Disorders:			
Facility Charges	$250 Copay per admission, then 100%	$250 Copay per admission, then 100%; Deductible waived	40% after Deductible
Professional Fees	90%	70%; Deductible waived	40% after Deductible
Inpatient Residential Treatment Center			
Facility Charges	$250 Copay per admission, then 100%	$250 Copay per admission, then 100%; Deductible waived	Not Covered
Professional Fees	90%	70%; Deductible waived	Not Covered
Plan Year Maximum Benefit	180 days		
Outpatient:			
Office Visits	$10 Copay, then 100%	$30 Copay, then 100%; Deductible waived	40% after Deductible
Applied Behavioral Analysis	$15 Copay, then 100%	$20 Copay, then 100%; Deductible waived	40% after Deductible
Partial Hospitalization & Intensive Outpatient	100%	$40 Copay, then 100%; Deductible waived	Not Covered
All Other Outpatient Care	100%	70%; Deductible waived	40% after Deductible

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
NOTE: Any visit maximums regarding home health care and outpatient therapies (as applicable) will not apply to Mental Disorders or Substance Use Disorders.			
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%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Professional Fees	$1,000 Copay per occurrence, then 100%	Paid at smhCare level of benefits	Paid at smhCare level of benefits
Lifetime Maximum Benefit	1 Surgical Procedure		
NOTE: Morbid Obesity is only covered at Tampa General Hospital.			
Nutritional Counseling			
Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder	100% (Only allowed at SMH or ACH)	$30 Copay, then 100%; Deductible waived	40% after Deductible
All Other Nutritional Counseling	$35 Copay, then 100% (Only allowed at SMH or ACH)	Not Covered	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Outpatient Therapies (physical, speech, occupational)	$25 Copay, then 100% (Only allowed at SMH or ACH)	$40 Copay, then 100%; Deductible waived (Non-Facility) ($80 Copay, then 100%; Deductible waived (Facility))*	40% after Deductible
Combined Plan Year Maximum Benefit	30 visits (additional visits may be allowed if Medically Necessary)		
*NOTE: Covered Persons under the age of 18 will be covered at the smhCare Tier 1 level of benefits.			
Physician's Services			
Inpatient/Outpatient Services	90%	70%; Deductible waived	40% after Deductible
Office Visits:			
Primary Care Physician	$10 Copay*, then 100%	$30 Copay*, then 100%; Deductible waived	40% after Deductible
Specialist	$35 Copay*, then 100%	$55 Copay*, then 100%; Deductible waived	40% after Deductible
Physician Office Surgery	$50 Copay*, then 100%	70%; 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)	100% (SMH and ACH Only)	70% after Deductible	40% after Deductible

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
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)			
Hospital	$100 Copay, then 100% (SMH and ACH Only) (100% at SMHCS only)	$150 Copay, then 100%; Deductible waived	40% after Deductible
Office/non-Hospital	Not Applicable	$125 Copay, then 100%; Deductible waived	40% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	$250 Copay per admission, then 100%	$200 Copay per day, then 100%; Deductible waived (up to 10 days) 100%; Deductible waived (days 10-180)	Not Covered
Combined Plan Year Maximum Benefit	180 days (if not at SMHCS Facilities)		
Sleep Disorders	$35 Copay, then 100%	70% after Deductible	40% after Deductible
Sterilization (Vasectomy)	100%	100%; Deductible waived	40% after Deductible
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.			
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

EXTENDED PLAN	TIER 1: smhCare PREFERRED PROVIDERS (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Temporomandibular Joint Dysfunction (TMJ)	$500 Copay per occurrence, then 100%	Deductible, then $500 Copay per occurrence, then 70%	Deductible, then $500 Copay per occurrence, then 40%
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	$250 Copay per admission, then 100%	Paid at smhCare level of benefits (smhCare and Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
Professional Fees	90%	Paid at smhCare level of benefits (smhCare and Aetna IOE Program)* Not Covered (All Other Network Providers)	Not Covered
* 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	$25 Copay*, then 100%	$60 Copay*, then 100%; Deductible waived	Deductible, then $120 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%	Not Covered	Not Covered
Diabetes and Nutrition Program	100%	Not Covered	Not Covered
Heart Failure Clinic	100%	Not Covered	Not Covered
Lung Health Clinic	100%	Not Covered	Not Covered
Secondary Stroke and TIA Prevention Clinic	100%	Not Covered	Not Covered
Wig (see Eligible Medical Expenses)	$50 Copay	$50 Copay, then 100%; Deductible waived	$50 Copay, then 100%; Deductible waived
Maximum Benefit every 2 Years	$500		
All Other Eligible Medical Expenses	90%	70% after Deductible	40% after Deductible

EXHIBIT G

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.		
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) Single Family	$6,000 $12,000	
Retail Pharmacy: 30-day supply		
Generic Drug	$10 Copay	$12 Copay
Preferred Drug	$40 Copay	$40 Copay
Non-Preferred Drug	$70 Copay	$70 Copay
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	$125 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.		
Retail Pharmacy: 90-day supply		
Generic Drug	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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	$10 Copay	$25 Copay
Preferred Drug	$40 Copay	$80 Copay
Non-Preferred Drug	$70 Copay	$140 Copay
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.

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 H

PRESCRIPTION DRUG PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; sexual dysfunction/impotence medication; growth hormones and contraceptives (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for certain medications that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for certain medications that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

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.

Step Therapy

What is Step Therapy?
Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as "Step 1" Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Plan Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as "Step 2" Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are generic drugs proven to be safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- Back-up drugs - Step 2 and Step 3 drugs - are brand-name drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?
The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate. Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher Copay if the front-line or Step 2 back-up drugs are not appropriate.

If on October 1, 2026, the Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months, he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

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.

Specialty Drug means those Prescription Drugs, medicines, agents, substances and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.