---BRONZE-2--- SCHEDULE OF MEDICAL BENEFITS

Maximum Annual Benefit for Medical Care Unlimited

		Comments
Plan Year Deductible: Per Covered Person Per Family	 $0 $0	
Plan Year Out-of-Pocket Maximum: Per Covered Person Per Family	 $8,000 $16,000	Includes medical and prescription drugs eligible expenses.
The charges for the following do not accrue to the Out-of-Pocket Maximum: • Cost Containment Penalties • Expenses incurred for Non-Covered Services		

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
HOSPITAL BENEFITS		
Inpatient Hospital Services	$1,500 Co-pay per Admission, then 100% *Limited to five (5) days per plan year combined with inpatient mental health and inpatient substance abuse.*	*Pre-notification required.* Benefit based on Semi-private room rate. Refer to "Maternity Inpatient Hospital" for additional benefit information.
Maternity Services *Includes, but is not limited to facility, professional and physician fees for uncomplicated maternity related care.*	$3,400 Co-pay, then 100%	*Pre-notification required.* This applies only to maternity expenses. Genetic testing at birth is limited to a $500 benefit per pregnancy.
Emergency Room	$750 Co-pay, then 100% *Limited to one (1) visit per plan year*	Co-pay is waived if admitted.
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS		
Inpatient Mental Health Treatment	$1,500 Co-pay per Admission, then 100% *Limited to five (5) days per plan year combined with inpatient hospitalization and inpatient substance abuse.*	*Pre-notification required.*
Mental Health Treatment *(Office Setting)*	$75 Co-pay, then 100% *Limited to four (4) visits per plan year combined with substance abuse and specialist office visits.*	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS *(continued)*		
Inpatient Substance Abuse Treatment	$1,500 Co-pay per Admission, then 100% *Limited to five (5) days per plan year combined with inpatient hospitalization and inpatient mental health.*	*Pre-notification required.*
Substance Abuse Treatment *(Office Setting)*	$75 Co-pay, then 100% *Limited to four (4) visits per plan year combined with mental health and specialist office visits.*	This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*
MISCELLANEOUS SERVICES AND SUPPLIES BENEFITS		
Home Health Care	$75 Co-pay, then 100% *Limited to six (6) visits per plan year*	
Ambulance Service	100%	Limited to one occurrence per plan year. Air ambulance is not covered.
Clinical Trials	Paid as any other benefit	Refer to *Clinical Trials* in the *Covered Medical Expense* section.
PROFESSIONAL SERVICES BENEFITS		
Surgical Services *Inpatient* *Outpatient* *Facility and professional fees* *Office*	$750 Co-pay, then 100% *Limited to two (2) procedures per plan year* $750 Co-pay, then 100% *Limited to one (1) procedure per plan year* $100 Co-pay, then 100% *Limited to one (1) procedure per plan year*	This co-payment is in addition to any other applicable place of service co-payment as shown in this schedule. *Pre-notification required for all In-patient and Outpatient surgical procedures.* Pre-notification not required for office surgery.
Physician's Office Visits *Includes family and general physician, internist and OB/GYN physician*	$50 Co-pay, then 100% *Limited to four (4) visits per plan year*	This benefit is for a billed office visit only. Other services rendered during an office visit will be considered as shown in this document. This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*
Specialist's Office Visits	$75 Co-pay, then 100% *Limited to four (4) visits per plan year combined with mental health and substance abuse office visits.*	This benefit is for a billed office visit only. Other services rendered during an office visit will be considered as shown in this document. This includes video and phone consultations when deemed a medically appropriate alternative to an in-office visit. *(this will accrue toward the applicable visit limit)*

Benefits and Services	Plan Pays *Allowed Amount	Comments
The Plan does not cover out-of-network services except as required under the provisions of this document.		
PROFESSIONAL SERVICES BENEFITS *(continued)*		
Urgent Care	$75 Co-pay, then 100% *Limited to two (2) visits per plan year*	
Diagnostic X-ray & Laboratory Expenses *Non-hospital based*	$75 Co-pay, then 100% *Limited to three (3) tests/procedures per plan year*	
Advanced Imaging	$750 Co-pay, then 100% *Limited to one (1) visit per plan year*	Includes MRI, MRA, CT / PET Scan and nuclear imaging.
REHABILITATION THERAPY BENFITS		
Physical Therapy Occupational Therapy	$75 Co-pay, then 100% *Limited to a combined four (4) visits per plan year*	
PREVENTIVE CARE BENEFITS		
Preventive Services *As established by section 2713 of the Affordable Care Act (ACA)*	100%	Refer to the *Covered Medical Expense* section under *Preventive* for additional information.
Well Child Care	100%	
Well Adult Care	100%	
Well Women Care	100%	Breast Pump reimbursement is limited to $125.
Mammogram	100%	Includes 3D mammograms.
GYN & Pap	100%	
PSA Testing	100%	
Colonoscopy	100%	
Well Care includes reimbursement for the following services: office visits, physical examination, laboratory tests, x-rays, immunizations and cancer screenings.		

- Allowed amount - The Plan will consider the allowed amount designated by the Preferred Provider Organization.
- UCR -The Plan will consider the Usual and Customary and Reasonable amount of the services based on the geographic location of the provider of service.

This schedule is not all inclusive. Refer to the Covered Medical Expenses and Medical Exclusions and Limitations sections for more information.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS ***(Available through a separate Pharmacy Benefit Manager)***			
Plan Year Deductible: Per Covered Person	$500		
	Retail Covered Person Pays *30-day supply* ***(After Deductible)***	**Mail-Order Covered Person Pays** *Up to 90-day supply* ***(After Deductible)***	Prescription drugs regardless of tier will be limited to a $500 per month benefit for any 30-day fill and $1,500 for a 90-day supply.
Generic* *(tier-1)*	40% *(Deductible Waived)*	40% *(Deductible Waived)*	
Preferred Brand *(tier-2)*	40%	40%	
Non-Preferred *(tier-3)*	40%	40%	
Specialty Medications *(tier-4)***	Not Covered	Not Covered	

*** The Plan will cover charges for any preventive care drugs as required by the ACA. The Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care, such as covering a generic drug without cost sharing and imposing cost sharing for equivalent branded drugs.**

Your Doctor may prescribe a name brand drug that has a lower cost generic drug equivalent. If either drug is acceptable to your Doctor, you are encouraged to choose the generic drug from your pharmacist. However, if you choose the name brand drug, you must pay the difference in cost between the generic and name brand.

SCHEDULE OF BENEFITS

HOSPITAL INDEMNITY EXTENSION BENEFIT PROGRAM

Welcome to the Hospital Indemnity Benefit Program!

The information below is being provided to allow individuals to easily understand and utilize this important benefit so please read carefully. This information, also referred to as a schedule of benefits ("SOB"), will describe the Hospital Indemnity ("HI") Extension Benefits that are automatically available to Employees and their dependents upon enrollment in the medical benefit program being made available through the Cooperative.

HOSPITAL INDEMNITY BENEFIT

The following benefits are payable when a Participant has a qualified Hospital confinement. To receive benefits, each Participant must be enrolled in this Program and complete the applicable Waiting Period (see Hospital Indemnity Only definitions). Unless otherwise indicated below, any benefit amount, limitation or benefit maximum applies to each Participant.

Hospital Indemnity Benefit(s) Summary	
Hospital Confinement	
Reimbursement Amount	$2,000 per Day *(Day 6 through discharge date)*
Elimination Period	5 Days
Limitation	365 Days per condition (diagnosis)
Benefits are available for most Medically Necessary treatment of an Illness or Injury (see exclusions). Benefits are not available for confinements initiated during the Waiting Period (see definition). See HOSPITAL INDEMNITY EXCLUSIONS for additional benefit limitations/exclusion information.	

HOW TO FILE A HOSPITAL INDEMNITY CLAIM.

There are several ways a Participant may file a claim. Claims may be mailed or faxed to S&S, the Program's claims administrator. *CAUTION: The Participant should be careful when utilizing the fax method and make certain there is proper security in place for the fax machine from which they are sending documentation. The S&S recipient fax is HIPAA secure.*

- Mailing Address: S&S Health, P.O. Box 46511, Cincinnati, OH 45246-0511
- Fax Address: (513) 772-9174

CUSTOMER SERVICE.

- Customer Service Toll-free Number: (888) 288-7040
- Hours of Operation: Monday – Friday (except holidays) from 8:00 a.m. – 5:00 p.m. ET

EXCLUSIONS

HOSPITAL INDEMNITY EXCLUSIONS: Benefits are not available from the Program for charges arising from the following:

After the Termination Date. Confinements incurred by the Participant on or after the date coverage terminates.

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding 24 consecutive hours.

Cosmetic Surgery. That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness, or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health, unless specifically mentioned otherwise. This includes but is not limited to long-term care.

Experimental. That are Experimental or Investigational.

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Illegal Acts. That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that resulted a conviction.

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

No Coverage. That are Incurred at a time when the applicable Participant and/or Dependent is not enrolled in the Program.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant had such mandatory coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family-owned vehicle or a pedestrian.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Subrogation, Reimbursement, and/or Third-Party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Substance Abuse. Confinements related to alcohol or substance abuse, except for substance abuse innocently sustained at the hands of a licensed physician.

Suicide or Self-Inflicted. That are Incurred due to an intentionally self-inflicted Injury or Illness not definitively (a) resulting from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

Vehicle Accident. That are for treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot.

DEFINITIONS

"**Calendar Year**" shall mean the 12-month period from January 1 through December 31 of each year.

"Cooperative" shall mean The Small business Agency (SB/A) Cooperative is a Non-Profit "Agency" Cooperative Corporation filed in the state of Colorado and able to operate in all fifty states and US Territories. For further information, visit www.sbacorhealth.com/about-us/.

***Plan is sponsored by SB/A, administered by S&S Health. ***

"Employee" shall mean an individual who is actively at work and enrolled in the Program as made available to them through their employer's medical benefit plan.

"Injury" shall mean an accidental bodily injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit. For purposes of this Program, non-complication pregnancies are considered an Illness, however, are subject to stated Exclusions.

"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical, diagnosis, treatment, and care to injured or sick persons, on an inpatient basis, with 24 hour a day nursing service by Registered Nurses.

"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a licensed physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, diagnosis or treatment of that Participant's Illness or Injury.

"Participant" shall mean an Employee and their dependents. A dependent is considered a Participant if they are the legal spouse or natural born child/stepchild under the age of 26 of the Employee.

"Period of Confinement" shall mean a Hospital confinement exceeding twenty-four (24) consecutive hours beginning with the admission date and ending on the date of discharge.

"Waiting Period" shall mean the seven (7) calendar days for non-pregnancy related Hospital admissions immediately following enrollment in the Program. Pregnancy related Hospital admissions shall not be eligible for HI benefits for two hundred ninety-nine (299) days immediately following enrollment in the Program. The entire Hospital admission initiated during the Waiting Period shall be ineligible for the Hospital Indemnity benefit.