ARTICLE II
OVERVIEW OF BENEFITS

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are limited to the Maximum Allowable Charge as defined; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are outlined under Defined Terms of this Plan.

This Plan pays Covered Expenses pursuant to the Maximum Allowable Charge, which is defined in Article XI of this document. **Plan Participants are responsible for any amounts determined to be in excess of the Maximum Allowable Charge.**

Precertification of certain services is required by the Plan. Precertification provides information regarding coverage before the Plan Participant receives treatment, services or supplies. ***A Precertification of services by CRITIQUE is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.***

If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be *reduced by $250* and such reduction will not go toward the Maximum Out-of-Pocket Amount.

All services requiring Precertification, as noted in the Summary Plan Description are to be authorized in advance by the CRITIQUE, except for emergencies. The Plan Participant or their representative is required to call the phone number for Precertification located on the back of their ID card for the services specified in the Summary of Benefits section at least five (5) working days prior to the services being rendered. The Plan Participant or their representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Precertification determinations and service repricing. If Precertification is not obtained for these benefits the Plan payment for any expenses associated with these benefits will be **reduced by $250** and such reduction will not go toward the Maximum Out-of-Pocket Amount. This provision does not apply to urgent care admissions or if surgery is performed within 24 hours of the admission. Urgent care or Emergency admissions should be authorized as soon as reasonably possible.

Contact Critique at (888) 272-4002 to obtain Pre-Certification of a non-emergency admission and services.

PROVIDER INFORMATION

The Plan has contracted with medical Provider Networks to access discounted fees for services for Plan Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Plan Participants:

(1) The Plan provides different levels of benefits based on whether the Plan Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Plan Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

- The Network Provider level of benefits is payable when a Plan Participant receives Emergency care either out-of-area or at a Non-Network Hospital for an Accident Bodily Injury or Emergency.

(2) If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Plan Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Plan Participants are not responsible for

any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given Assignment of Benefits or to proactively prohibit Assignment of Benefits to anyone, including any Provider, at its discretion.

(3) To receive benefit consideration, Plan Participants must submit claims for services provided by Non-Network Providers to the Claims Administrator. Network Providers have agreed to bill the Plan directly, so that Plan Participants do not have to submit claims themselves.

(4) Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

To request a Network Provider listing or to verify whether a Provider is a Network Provider or Non-Network Provider, refer to your ID card for your network information, call Rocky Mountain Administrators (RMA) at (800) 383-8808 or visit www.rockymountainadministrators.com **BEFORE** the charges are Incurred.

Additionally, care provided by Monument Health Hospitals will be available at a lower out of pocket cost to the Plan Participant.

Contact CRITIQUE at (888) 272-4002 to Precertify for Inpatient, Outpatient, Emergency and non-Emergency services.

ARTICLE III
MEDICAL BENEFITS SCHEDULE

	MEDICAL BENEFITS
Claims must be received by the Claims Administrator within ***365 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.	
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**
DEDUCTIBLE, PER CALENDAR YEAR	
Per Plan Participant Per Family Unit	$2,500 $5,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Plan Participant Per Family Unit	$4,500 $9,000
The Maximum Out-of-Pocket Amount includes Coinsurance and Deductibles applied toward covered medical benefits as shown above. The following expenses do not count toward the Maximum Out-of-Pocket Amount and will not be paid at 100%, even when the Maximum Out-of-Pocket Amount has been met: • Any penalties for failure to Precertify; • Charges in excess of the Maximum Allowable Charge; or • Expenses Incurred for non-covered services.	
Maximum Allowable Charge for Covered Expenses is limited to the Reasonable and Allowed Amount as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.	

DESCRIPTION	MONUMENT HEALTH FACILITIES	ALL OTHER PROVIDERS
Physician Services		
Office Visits	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Specialist Office Visit	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Accidental Injury Benefit *First $500 payable at 100%, Deductible waived.*	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Allergy Injections, Testing and Serums	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Ambulance	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Ambulatory Surgical or Outpatient Surgical Facility	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Cardiac Rehabilitation Therapy	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Children's Eye Exam – (Under age 19)	No cost to Plan Participant, Deductible does not apply.	No cost to Plan Participant, Deductible does not apply.

Chiropractic Care Limited to $750 per Calendar Year.	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Diabetes Treatment	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Dialysis	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Diagnostic Testing		
X-ray and Lab	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Advanced Imaging (CT scans, MRIs, MRAs and PET scans) and Nuclear Medicine	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Durable Medical Equipment and Prosthetics	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Emergency Room Services	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Home Health Care	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Hospice Care Six (6) month benefit period.	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Hospital Services	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Human Organ and Tissue Transplants ***See LIMITATIONS**	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Infertility Services		
Diagnosis of Underlying Condition	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Infertility Treatment	Not Covered	Not Covered
Maternity Care	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Morbid Obesity Surgery Limited to $15,000 Lifetime Maximum ***See LIMITATIONS**	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Novel Coronavirus (COVID-19)		
COVID-19 Testing	No cost to Plan Participant, Deductible does not apply.	No cost to Plan Participant, Deductible does not apply.
COVID-19 Treatment	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Occupational Therapy	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Orthotics Limited to $500 per Calendar Year	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.

Physical Therapy	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Preventative Care		
Routine Well Care (Birth through Adult)	No cost to Plan Participant, Deductible does not apply.	No cost to Plan Participant, Deductible does not apply.
Influenza Vaccinations	No cost to Plan Participant, Deductible does not apply.	No cost to Plan Participant, Deductible does not apply.

Routine Well Care services will be subject to age, and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Routine Well Care services will include, but will not be limited to, the following routine services: Office visits, routine physical exams, prostate screening, sterilization procedures patient education and counseling for men, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well childcare examinations.

Women's Preventive Services, will include, but will not be limited to, the following routine services: Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women

Maximum Allowable Charge for Covered Expenses is limited to the Reasonable and Allowed Amount as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.

DESCRIPTION	MONUMENT HEALTH FACILITIES	ALL OTHER PROVIDERS
Private Duty Nursing (Inpatient Only)	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Second & Third Surgical Opinion	No cost to Plan Participant.	No cost to Plan Participant.
Skilled Nursing Facility Limited to 120 days per Calendar Year.	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Speech Therapy	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Temporomandibular/Craniomandibular Joint Disorder (TMJ) *Limited to Surgery Only*	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.
Treatment of Mental or Nervous Disorders or Substance Abuse	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.

Urgent Care	10% after Deductible is met.	20% after Deductible is met. Subject to the Maximum Allowable Charge.

Precertification. The following services require Precertification:

- All Inpatient Stays;
- Chemotherapy and Radiation;
- Clinical Trials;
- Home Health Care Services;
- Hospice Services;
- Outpatient Surgical Procedures;
- Rehabilitation program (cardiac, chemical dependency, pain management or pulmonary);
- Skilled Nursing Care; and
- Transplant Services.
- Colonoscopies

All services requiring Precertification, as noted in the Summary Plan Description are to be authorized in advance by CRITIQUE, except for emergencies. The Plan Participant or their representative is required to call the phone number for Precertification located on the back of their ID card for the services specified above at least five (5) working days prior to the services being rendered. The Plan Participant or their representative must identify the services to be rendered and the associated Diagnosis and Procedure Codes necessary for Precertification determinations.

If Precertification is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care will be reduced by $250 and such reduction will not go toward the Maximum Out-of-Pocket Amount.