

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

There is no Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

Network:	\$4,500 INDIVIDUAL	Out-of-Network:	\$20,000 INDIVIDUAL
	\$9,000 FAMILY		\$40,000 FAMILY

The Network Annual Out-of-pocket Maximum and the Out-of-Network Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Coinsurance and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- **All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)**
- **Outpatient surgery**
- **Hospice**
- **Home Health Care**
- **Durable Medical Equipment > \$750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

SIARMED: \$250 per service or

Out-of-Network (US providers): 40% of the total cost of the service.

THE NETWORK IS ADMINISTERED BY: SIARMED

The only Out-of-Network providers covered under this Plan are United States providers and only in the case of an Emergency. All other Out-of-Network providers are NOT covered.

NOTE: The following out-of-network services will be eligible expenses during the course of public health emergency relating to COVID-19 : Procedures and services through Exclusive Surgeries Solutions LLC; procedures and services through San Luis Walk in Clinic.

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are “Essential Health Benefits” as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit.

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Ambulance Services -Air and Ground	Included in Emergency Copay	Included in Emergency Copay	Out-of-Network only covered in the case of Emergency.
COVID-19 tests and vaccine administration	100%	100%	Includes testing, related services, and vaccine administration to the extent required by law.
Dental Hospitalization and Dental Services Office Visits	100% after a \$25 Copay per visit	Not Covered	
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	100% after a \$5 Copay per visit	Not Covered	In network covered services only include: <ul style="list-style-type: none"> • Nebulizer • Breast pump
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level.
Emergency visit	100% after a \$150 Copay per visit	100% after a \$150 Copay per visit	Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
Urgent Care (visit only)	100% after a \$20 Copay per visit	Not Covered	
Hearing Aid Exams	100% after a \$5 Copay per visit	80%	Hearing Aids LIMITED to 1 per ear, to a maximum benefit of \$1500 in a 3 calendar year period.
Hearing Aids	100%	80%	

Attachment A – Effective March 1, 2022

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Home Health Care	Not Covered	Not Covered	
Inpatient Hospital Services (Non- Emergency)/Outpatient Hospital Visits for more than 12 hours Outpatient surgery (less than 12 hours)	100% after a \$50 Copay per visit 100% after a \$25 Copay per visit	50% 50%	Out-of-Network only covered in the case of Emergency.
Inpatient and Outpatient Physician Services Primary Care Physician/Specialist Office Visits (includes lab and X-ray) Inpatient Visit Surgery (Physician's office) Surgery (other) Physician Services – Pathology, Anesthesiology , or Radiology	100% after a \$5 Copay per visit 100% 100% 100%	Not Covered Not Covered Not Covered Not Covered	
Maternity Prenatal visits Initial visit All other visits Hospital Services Birthing Centers	100% after a \$5 Copay per visit 100% 100% after a \$50 Copay per visit Not available	Not Covered Not Covered Not Covered Not Covered	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
<p>Mental/Nervous Disorders and/or Substance Abuse</p> <p>Inpatient treatment</p> <p> Visits for more than 12 hours</p> <p> Visits for less than 12 hours</p> <p>Outpatient treatment</p>	<p>100% after a \$50 Copay per visit</p> <p>100% after a \$25 Copay per visit</p> <p>100% after a \$5 Copay per visit</p>	<p>50%</p> <p>50%</p> <p>Not Covered</p>	<p>Inpatient treatment: Out-of-Network only covered in the case of Emergency.</p>
<p>Outpatient Diagnostic Tests</p> <p> Complex - MRI, CT, PET Scans</p> <p> Other X-rays and Laboratory tests</p>	<p>100% after a \$25 Copay per visit</p> <p>100% after a \$5 Copay per visit</p>	<p>Not Covered</p> <p>Not Covered</p>	
<p>Outpatient Prescription Drugs</p> <p> Generic Drugs</p> <p> Name Brand Drugs</p>	<p>100% after a \$2 Copay</p> <p>100% after a \$5 Copay</p>	<p>Not Covered</p> <p>Not Covered</p>	
<p>Preventive Care Services</p> <p> Pediatric and Adult Preventive Care</p> <p> Immunizations, inoculations, vaccinations</p> <p> Sterilization – limited to Employee and covered Spouse only</p>	<p>100%</p> <p>100%</p> <p>100%</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>	<p>Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.</p>

Attachment A – Effective March 1, 2022

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Rehabilitation and Habilitation Services	100% after a \$5 Copay per visit	Not Covered	Siarmed covered services in Mexico include physical and speech therapy only.
Skilled Nursing Facility	Not Covered	Not Covered	
All other Covered Expenses	100%	Not Covered	