MEDICAL SCHEDULE OF BENEFITS—BASE PLAN

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

Benefit Year is from October 1st-September 30th.

Deductibles:	
Benefit Year Deductible: Benefits with an "*" indicate that the Benefit Year Deductible is waived.	$800 per Participant per Benefit Year and $1,600 per family per Benefit Year (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities).
Benefit Year Deductible and any Copays must be met before any Covered Expenses are paid.	
Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductible.	

Maximums:	
Annual Out-of-Pocket Maximum: Includes Benefit Year Deductible, Medical Copays and Medical Coinsurance.	$4,000 per Participant and $8,000 per family (includes Non-Participating Providers of ambulance services, Emergency Services, and Non-Emergency Services furnished at certain Participating Provider facilities). Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums. Routine Vision, Prescription Drug Copays and Penalties do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.

Preauthorization Requirements:

- **All Admissions require Preauthorization**—If Preauthorization is not obtained for services, room and board charges will be denied. Other services may also require Preauthorization. **Please see the Schedule of Benefits and Plan of Benefits for more information.**
- **These services require Preauthorization.** If Preauthorization is not obtained, you will be responsible for the first $500 in payable charges.
  - Admissions for physical rehabilitation
  - Ambulance (non-emergency)
  - Human organ and/or tissue Transplants
  - Durable Medical Equipment when the purchase price or rental cost of the equipment is $500 or more
  - Experimental or Investigational procedures (if covered)
  - Inpatient and Outpatient services for Mental Health
  - Inpatient and Outpatient services for Substance Use

INPATIENT HOSPITAL SERVICES: Preauthorization required	PPO:	Non-PPO:
Room and Board:	70%	60%
All other (non-emergency) Benefits in a Hospital during an Admission (including, for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services)	70%	60%[2]
Hospital Admission resulting from an emergency room visit:	70%	70%[1]
Skilled Nursing Facility: Within 7 days of a 5-day stay—60 days per Benefit Year maximum	70%	60%
Residential Treatment Facility:	70%	60%
Physical Rehabilitation Facility:	70%	60%
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	70%	60%
Newborn Nursery:	70%	60%
Physician Expenses:	70%	60%
Radiology/Pathology Charges:	70%	60%
Mental Health or Substance Use (Non-Emergency Services):	70%	60%[1 2]
Mental Health or Substance Use, Physician Charges (Non-Emergency Services):	70%	60%[1 2]
Mental Health or Substance Use (Emergency Room Admissions):	70%	70%[1 2]
Mental Health or Substance Use, Physician Charges (Emergency Room Admissions):	70%	70%[1 2]
Anesthesia:	70%	60%[1 2]

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

OUTPATIENT SERVICES:	PPO:	Non-PPO:
Hospital and Ambulatory Surgical Center Charges:	70%	60%[1 2]
Hospital and Physician Charges (Non-Emergency Services):	70%	60%[1 2]
Emergency Room Charges:	70%	70%
Preadmission Testing:	70%	60%[1 2]
Anesthesia:	70%	60%[1 2]
Cardiac Rehabilitation:	70%	60%[1 2]
Diagnostic X-ray, Laboratory, Pathology, and Radiology:	70%	60%[1 2]
Diagnostic Colonoscopies: Includes charges associated with colonoscopies (Anesthesia, Lab, Pathology, etc.)	70%	60%
Mental Health or Substance Use (Non-Emergency Services): Preauthorization required	70%	60%[1 2]
Mental Health or Substance Use (Emergency Room) charges:	70%	70%[1 2]
Urgent Care:	$30 Copay, then *100%	60%

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

PHYSICIAN OFFICE SERVICES:	PPO:	Non-PPO:
Surgery	70%	60%
Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, Supplies and Injections billed by the Physician's office, Allergy Services, Accident Services, Mental Health and Substance Use	$30 Copay, then *100%	60%
Birth Control Device Surgery: Including IUD, Implanon and Norplant, etc.	*100%	60%
Radiology/Pathology/X-ray, Lab, Supplies and Injections not billed by Physician's office:	70%	60%

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care: Limited to $500 per Benefit Year—Includes Office Visit and X-rays	$30 Copay, then *100%	60%
Hospice Care: Limited to 30 days inpatient—40 visits outpatient per Benefit Year	70%	60%
Bereavement Counseling: Limited to 12 visits with a maximum of $25 allowed per visit	70%	60%
Home Health Care: Limited to 100 visits per Benefit Year	70%	60%
Durable Medical Equipment: Preauthorization is required if $500 or more	70%	60%
Second Surgical Opinion (not mandatory):	$30 Copay, then *100%	60%
Human Organ/Tissue Transplants: Preauthorization required—Covered only at a facility approved by PAI in writing—Physician Charges are subject to the Benefit Year Deductible.	70%	60%
Air Ambulance Service:	70%	70%[1] [2]
Ground Ambulance Service:	70%	70%[1] [2]
Physical Therapy:	70%	60%
Occupational Therapy:	70%	60%
Speech Therapy:	70%	60%
Prosthetics:	70%	60%
Orthotics:	70%	60%
Radiation Therapy and Chemotherapy:	70%	60%
MRI and CT Scans:	70%	60%
Diabetic Supplies and Self-injectables:	70%	60%
All Other Covered Benefits:	70%	60%

[1]When services are received from a Non-PPO provider, and the Non-PPO Provider satisfies advance patient notice and consent requirements, the Participant may be required to pay the balance of the Provider's charge if the Allowable charge is less.

[2]Non-PPO provider **at a PPO Provider Facility**: When services are received **from a Non-PPO provider in a PPO Provider Facility**, such services will be processed at the PPO benefit level. This means an application of the

appropriate PPO deductible and coinsurance. Otherwise, the Participant must pay the balance of the Provider's Charge, if greater than the Allowable Charge.

WELLNESS SERVICES:	PPO:	Non-PPO:
Annual Physical Exam: Includes Office Visits, Immunizations, X-rays and Labs	*100%	60%
Annual Gynecological Exam or Prostate Exam: Limited to 1 per Participant per Benefit Year	*100%	60%
Colonoscopy: Age 50 and above	*100%	60%
Well-Child Care: Includes Office Visits, Routine Physical Examination, Labs, X-rays, Hearing Tests, Vision Tests and Immunizations	*100%	60%
Routine Mammograms: Subject to these age guidelines: one mammogram is covered between ages 35 and 39 and each year for women 40 and over.	*100%	60%
BlueCross BlueShield of South Carolina Mammography Network Provider:		
Routine Mammogram: BlueCross BlueShield of South Carolina Mammography Benefit subject to these age guidelines: one mammogram is covered between ages 35 and 39 and each year thereafter for women 40 and over.	*100%	

Note: Benefits covered per ACA guidelines with no cost sharing for services at a Participating Provider.

ROUTINE VISION CARE:	
Exam and/or Hardware: Per Employee Benefit Year Limit: Per Dependent Benefit Year Limit:	 *100% up to $500 *100% up to $250
HEARING IMPAIRMENT:	
Treatment of Hearing Impairment: Including Hearing Aids Per Participant per Benefit Year Limit	 *100% up to $500

PRESCRIPTION DRUG SCHEDULE OF BENEFITS- BASE PLAN

Prescription Drug Benefits are subject to all of the Prescription Drug Exclusions listed in this Document.
Participating Pharmacy: Copay per prescription (34-day supply Maximum per prescription)
Mail Service/Home Delivery Pharmacy: (90-day supply maximum per prescription)

Prescription Drug	34-day Supply	90-day Supply
Generic Drugs	$10 Copay, then 100%	$20 Copay, then 100%
Preferred Drugs	$35 Copay, then 100%	$70 Copay, then 100%
Non- Preferred Brand Drugs	$70 Copay, then 100%	$140 Copay, then 100%
Specialty Drugs	$250 Copay, then 100%	$500 Copay, then 100%
Prescription Drug Maximums:		
Prescription Drug Annual Out-of-Pocket Maximum:	$5,000 per Participant per Benefit Year at a Participating Provider and $10,000 per family per Benefit Year at a Participating Provider. Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met.	

BASE PLAN and BUY-UP PLAN will utilize Prescription Drug Programs listed below:

Prior Authorization Program
A quality and safety program that promotes the proper use of certain medications by requiring prior approval before the Plan will cover them.

Quantity Management Program:
The Quantity Management Program is a quality and safety program that promotes the safe use of medications. The program limits the amount of some medications that are covered.

Step Therapy Program:
Through the Step Therapy Program Participants are required to try cost-effective "First Choice" medications before trying (or "stepping up to") more expensive "Second Choice" medications.

If Prior Authorization is not obtained, benefits may be denied. Please refer to www.paisc.com for a complete list of Prescription Drugs and Specialty Drugs that require Prior Authorization.

Participants will pay the difference in cost, if a Brand Name Drug is requested when there is a Generic available.

Some specialty medications may qualify for third party Copay assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party Copay assistance is used, the Participant shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copay or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Specialty Drugs must be obtained through Optum Specialty Pharmacy. For questions regarding Specialty Drug cost, please contact Optum Specialty Pharmacy at 877-259-9428.

For a list of Preferred/Non-Preferred Brand Name Drugs, please reference https://www.paisc.com/members.aspx.