

**National Health Care, Inc and Affiliates  
Voluntary Employee Benefit Association Plan  
Premium Plan  
Medical and Prescription Drug Benefit Schedule  
Effective January 1, 2022**

NOTE: “The information provided is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.”

<b>Deductible and Out-of-Pocket Maximum</b>	
<b>Calendar Year Deductible</b>	\$750 Individual \$2,000 Family
<b>Out-of-Pocket Maximum*</b> (Includes Deductible)	\$7,900 per person \$15,800 per family
*When the Out-of-Pocket Maximum is reached, Plan payments will increase to 100%. The following expenses do not apply toward your Out-of-Pocket Maximum: non-covered expenses and charges that exceed Usual, Customary and Reasonable charges.	
<b>Provisions and Limitations</b>	
<i>Utilization Review Services</i>	
Hospital Pre-admission Certification; Concurrent Review; Discharge Planning and Maternity Care Review. Other services may require pre-certification. Please review plan document for details.	
<i>Hospital Pre-admission Certification</i>	
Certification is required for: Hospital Admissions; Treatment Facility Admissions; Convalescent Facility Admissions; Home Health Care; Hospice Care; Private Duty Nursing.	
<b>Covered Medical Expenses</b>	
Service	Plan Pays
<i>Hospital Expenses</i>	
<b>Inpatient Room &amp; Board &amp; Ancillary</b>	\$500 copay after deductible
<b>Inpatient Maternity Care</b>	\$500 copay after deductible
<b>Outpatient Facility (medical)</b>	\$500 copay after deductible
<b>Outpatient Facility (surgical)</b>	\$500 copay after deductible
<b>Outpatient Facility (DXL)</b>	100% after \$25 copay
<b>Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)</b>	100% after \$500 copay
<i>Physicians' and Surgical Expenses</i>	
<b>Inpatient Surgery**</b>	100% after deductible
<b>Inpatient Visits</b>	100% after deductible
<b>Outpatient Surgery (Hosp/ASC)</b>	100% after deductible
<b>Outpatient Surgery (office)**</b>	100% after \$40 copay
<b>Second and Third Surgical Opinions</b>	100% after deductible
<b>Pre Natal-Maternity Visits</b>	100%
<b>Specialist Office Visits</b> (Includes diagnostic and lab services)	100% after \$40 copay
<b>Office Visits – Primary Care Physician</b> Internist, General, Family Practitioner or Pediatrician (Includes diagnostic and lab services)	100% after \$30 copay

**\*\*Anesthesia is paid at the same level as Surgery**

**National Health Care, Inc and Affiliates  
Voluntary Employee Benefit Association Plan  
Premium Plan  
Medical and Prescription Drug Benefit Schedule  
Effective January 1, 2022**

<b>Covered Medical Expenses</b>	
<b>Service</b>	<b>Plan Pays</b>
<i><b>Mental Health Treatment Expenses</b></i>	
<b>Inpatient Hospital</b>	\$500 copay after deductible
<b>Inpatient Physician Visits</b>	100% after deductible
<b>Outpatient Visits</b>	\$40 copay
<i><b>Substance Abuse Treatment Expenses</b></i>	
<b>Inpatient Rehab</b>	\$500 copay after deductible
<b>Inpatient Detox</b>	\$500 copay after deductible
<b>Inpatient Physician Visits</b>	100% after deductible
<b>Outpatient Rehab Visits</b>	\$40 copay
<b>Outpatient Detox Visits</b>	\$40 copay
<i><b>Emergency Care***</b></i>	
<b>Emergency Room (Hospital)</b>	\$250 copay (copay waived if admitted)
<b>Emergency Room Physician</b>	100%
<b>Emergency Room Diagnostic</b>	100%
<b>Urgent Care Facility</b>	\$50 copay
<b>Retail Clinic</b>	\$30 copay
<i><b>Preventive Care Expenses*</b></i>	
<b>Immunization</b>	100%
<b>Routine Annual Physical Exam</b>	100%
<b>Routine Colorectal Screening</b>	100%
<b>Routine Diagnostic Procedures</b>	100%
<b>Routine Eye Exams</b>	100%
<b>Routine Gynecological Procedure</b>	100%
<b>Routine &amp; Digital 3D Mammography</b>	100%
<b>Well-Child Care</b>	100%
<b>Routine Hearing Screening</b>	100%
<i><b>Therapies</b></i>	
<b>Cardiac Rehab</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Chemotherapy/Radiation Therapy</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Dialysis</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Occupational Therapy</b>	\$45 copay
<b>Physical Therapy</b>	\$45 copay
<b>Respiratory Therapy</b>	\$45 copay
<b>Speech Therapy (Restorative purposes only)</b>	\$45 copay

\* Preventive Care are covered pursuant to PPACA/Health Care Reform guidelines

\*\*\*Emergency room Copayments will also be waived if the Member was directed by the treating physician at the Urgent Care Center to go immediately to an emergency room as the more appropriate medical setting for the required treatment.

**National Health Care, Inc and Affiliates  
Voluntary Employee Benefit Association Plan  
Premium Plan  
Medical and Prescription Drug Benefit Schedule  
Effective January 1, 2022**

<b>Covered Medical Expenses</b>	
<b>Service</b>	
<i>Other Covered Expenses</i>	
<b>Ambulance Service</b>	100%
<b>Allergy Injections</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Allergy Testing</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Allergy Serum</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Autism Behavioral Therapy</b>	Same as Mental Health Coverage
<b>Autism Therapies (PT/OT/ Speech)</b>	\$45 copay
<b>Bariatric / Gastric Bypass Surgery</b>	Not Covered
<b>Chiropractic/Spinal Manipulation</b>	\$45 copay
<b>Contraceptive Management</b>	100%
<b>Advanced Imaging, CT, MRI, Pet Scans (Freestanding Facility)</b>	100% after \$250 copay
<b>Advanced Imaging, CT, MRI, Pet Scans (Hospital Based)</b>	100% after \$500 copay
<b>Diagnostic, X-ray, and Lab (Freestanding Facility)</b>	100% after \$10 copay
<b>Diagnostic, X-ray, and Lab (Hospital Based)</b>	100% after \$25 copay
<b>Durable Medical Equipment</b>	70% of RBR
<b>Hearing Aids (under the age of 13)</b>	100%
<b>Hearing Exams (every 24 months)</b>	100% after \$45 copay
<b>Home Health Care</b>	100% after deductible
<b>Hospice Care - Inpatient</b>	\$500 copay after deductible
<b>Hospice Care – Outpatient</b>	100%
<b>Medical Supplies</b>	70% of RBR
<b>Nutritional Counseling</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Pre-Admission Testing</b>	100% after deductible
<b>Private Duty Nursing-Outpatient</b>	100%
<b>Orthotics</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Prosthetics</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Skilled Nursing &amp; Rehabilitative Facilities</b>	\$250 copay
<b>Sleep Studies</b>	100% after deductible
<b>Smoking Cessation Expenses</b>	100%
<b>Tubal Ligation</b>	100%
<b>Telemedicine – MeMD</b>	100%
<b>Vision Exam (every 24 months)</b>	100%
<b>All Other Eligible Medical Expenses</b>	100% after deductible

**National Health Care, Inc and Affiliates  
 Voluntary Employee Benefit Association Plan  
 Premium Plan  
 Medical and Prescription Drug Benefit Schedule  
 Effective January 1, 2022**

<b>Covered Medical Expenses</b>	
<b>Service</b>	
<i><b>Infertility</b></i>	
<b>Infertility Diagnostic</b>	Services rendered in office - \$45 copay Services rendered at facility - 100% after deductible
<b>Infertility Services</b>	Not Covered
<i><b>Prescription Drugs - Some prescriptions may require preauthorization</b></i>	
<b>Prescription</b>	<b>Coinsurance/Copay</b>
<b>Non-Maintenance Medication: Retail Pharmacy Generic</b> (Up to 30 days)	\$9 copay or less per prescription
<b>Non-Maintenance Medication: Retail Pharmacy Brand</b> (Up to 30 days)	70% up to \$300 Maximum
<b>Maintenance Medication: Retail Pharmacy Generic</b> (30/90 days)	\$18/\$54 or less per prescription (After 2 <sup>nd</sup> Fill)
<b>Maintenance Medication: Retail Pharmacy Brand</b> (30/90 days)	50% up to \$300/\$900 Maximum
<b>Maintenance Medication: Mail Order Generic</b> (Up to 90 days)	\$18 or less per prescription
<b>Maintenance Medication: Mail Order Brand</b> (Up to 90 days)	70% x 2 up to \$600 Maximum
<b>Specialty Medication*</b> (Up to 30 days)	60% up to \$300 Maximum

\*Must be order from Accredo

**National Health Care, Inc and Affiliates**  
**Voluntary Employee Benefit Association Plan**  
**Premium Plan**  
**Medical and Prescription Drug Benefit Schedule**  
**Effective January 1, 2022**

All benefits described in the 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; and that services, supplies and care are not Experimental and/or Investigational.

Referrals by PPO Physician to a Non-PPO Physician will be considered as Non-PPO Service. In order to receive PPO benefits, ask your Physician to refer you to listed PPO Physician (e.g. specialists, etc.).

However, if you utilize a PPO Provider for treatment and subsequently require services from a Physician under agreement with that provider is not associated with the PPO (e.g., Physicians, anesthesiologists, radiologists, pathologists, etc.) the charges will be considered at the In-Network benefit outlined on the Schedule of Medical Benefits and treated as a PPO Physician not subject to Out-of-Network provision.

All other limitations, requirements and provisions of this Plan will apply. This exception does not apply in the event of consultations and situations in which you and/or your Physician selected or had the opportunity to select a PPO Physician and exercised the right to receive services from a Non-PPO Physician. The Member must provide the proof that a provider does not exist within the 30-mile radius.

A Preferred Provider Organization (PPO) is a negotiated arrangement in which selected Health Care Provider (physicians and ancillary) contract to provide services for you and your eligible Dependents for a pre-determined price. Examples of PPO Professional Providers are Primary Care Providers, Specialist, Chiropractor and OB/GYN. The PPO Network also includes Ancillary Services. The PPO arrangement is beneficial to you, your provider and the Plan. You receive a more cost effective benefit, the Plan saves money because services are performed at lower costs, and the provider gains new patients. Additional information about the PPO option, as well as a list of in-network doctors and facility can be found on the MultiPlan website: <https://www.multiplan.com/mpipracanc>

**National Health Care, Inc and Affiliates  
 Voluntary Employee Benefit Association Plan  
 Premium Plan  
 Medical and Prescription Drug Benefit Schedule  
 Effective January 1, 2022**

Service	Calendar Year Maximum Benefit per Person
<i>Medical</i>	
Lifetime Maximum for all Eligible Medical Expenses	Unlimited
Autism Applied Behavior Analysis (ABA)	Same as any other Mental Health service benefit
Chiropractic / Spinal Manipulation Services	Up to 20 visits per calendar year
Hearing Aids	Limited to \$1,000 max per 24 months for a child to age 13
Hearing Exams	One every 24 months
Home Health Care Services	Up to 80 visits per calendar year
Infertility Diagnosis/Treatment	Limited to diagnosis and treatment of underlying medical condition only
Nutritional Counseling	Limited to 3 visits per calendar year
Outpatient Therapy Physical, Occupational & Speech	Limited to 30 visits per calendar year per therapy
Private Duty Nursing	Limited to 70 eight hour shifts per calendar year.
Skilled Nursing and Rehabilitation Facilities	Up to 60 days per calendar year
Spinal Manipulation	Limited to 20 visits per calendar year
Routine Vision Exam	One exam every 24 months and refraction per calendar year by an Optometrist or Ophthalmologist
<i>Prescription Drugs</i>	
<b>Maximum Supply Retail Pharmacy Prescriptions</b>	90 days
<b>Maximum Supply Mail Order Pharmacy Prescriptions</b>	90 days