FARMERS HOME FURNITURE

2022 SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance withthe terms and limitations of this Plan.

LEVEL IA PROVIDERS – Facilities and Providers billing as a Facility to include Fairview Park Hospital, Dublin; Meadows Memorial Vidalia and Memorial Medical Savannah, but not limited to:

LEVEL IB PROVIDERS – All other Facilities and Providers not listed above and billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug andSubstance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits		
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)		Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)		Unlimited
Deductible & Annual Out-of-Pocket	**Level IA/ Level IB Benefit** **Level II PPO Benefit**	**Level II Non-PPO Benefit**
Calendar Year Deductible • Per Covered Person • Family Limit* (Copays do not apply to Deductible)	 $250 $750	 $250 $750
Annual Out-of-Pocket Maximum (Includes Deductible, Medical Copays, Prescription Drug Copays and Dental Expenses for Covered Persons under age 19) • Per Covered Person • Family Limit*	 $2,000 $4,000	 Unlimited Unlimited

LEVEL IA BENEFITS – Payment Levels and Limits:

This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level IA Providers list and to charges for services rendered by Provider's billing "as a Facility." The benefitsshown apply to all such covered, licensed, accredited Providers of service **with regard to participation in a Preferred Provider Organization (PPO) network**.

LEVEL IB BENEFITS – Payment Levels and Limits:

This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level IB Providers list and to charges for services rendered by Provider's billing "as a Facility." The benefitsshown apply to all such covered, licensed, accredited Providers of service **without regard to participationin a Preferred Provider Organization (PPO) network**.

Utilization Review (UR) Notification Requirements		
Utilization Review required for the following services: • Inpatient Hospital/Facility Admissions • Outpatient Surgery • Select Diagnostic Medical Procedures • Home Health Care • Other Specified Level I and Level II Services	Non-compliance Penalty: $500	Non-compliance penalty applies for failure to notify Utilization Review. See Utilization Review (UR) Program section for additional information.
Hospital/Facility Inpatient Services		
Benefit Percentage For:	**Level IA/ IB Benefit**	**Maximum Benefits, Limits & Provisions**
Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges $250 per Confinement Copay applies.	UR Notification required or penalty applies. Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges $250 per Confinement Copay applies.	Contact Utilization Review for Coordination of Care.

Routine Newborn Care Inpatient Hospital Services (to date of baby's discharge)	100% of Allowable Claim Limits for nursery Room and Board/ancillary charges $250 per Confinement Copay applies.	Baby must be added as Dependent within thirty-one (31) days of birth to be eligible for this benefit unless coverage for Dependent children is in force.
Skilled Nursing Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges $250 per Confinement Copay applies.	Limited to sixty (60) days per Calendar Year. UR Notification required or penalty applies.
Rehabilitation Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges $250 per Confinement Copay applies.	UR Notification required or penalty applies.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/Residential Treatment Center	100% of Allowable Claim Limits for Room and Board/ancillary charges $250 per Confinement Copay applies.	UR Notification required or penalty applies.

Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room - Accidental Injury/Medical Emergency (ER Copay waived if admitted Inpatient)	100% of Allowable Claim Limits $250 ER Copay applies	UR Notification required if admitted Inpatient.
- Non-Emergency Illness	Not Covered	
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Diagnostic X-ray and Laboratory	100% of Allowable Claim Limits $50 Copay applies per day	
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	100% of Allowable Claim Limits $250 Copay applies per day	UR Notification required or penalty applies.
Routine Annual Mammogram, Bone Density Test, Other Routine Diagnostic Lab	100% of Allowable Claim Limits Copay waived	
Diagnostic Mammogram	100% of Allowable Claim Limits $50 Copay	
Routine Colonoscopy Facility Charges	100% of Allowable Claim Limits Copay waived	

Diagnostic Colonoscopy Facility Charges	100% of Allowable Claim Limits $250 Copay	
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Copay and Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits $250 Outpatient Surgery Copay applies	UR Notification required or penalty applies.

Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility	100% of Allowable Claim Limits $250 Copay applies per day	UR Notification required or penalty applies.
Psychological Testing	100% of Allowable Claim Limits $250 Copay applies per day	
Outpatient Therapy	100% of Allowable Claim Limits $250 Copay applies per day	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	UR Notification required or penalty applies.
Physical, Occupational and Speech Therapy Services, Cardiac and Pulmonary Rehabilitation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	UR Notification required or penalty applies. Limited to thirty (30) visits per Calendar Year for Physical Therapy.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claims Limits Deductible applies	
Hospice		

All Covered Expenses	100% of Allowable Claims Limits $250 per Confinement Copay applies	Limited to $10,000 Lifetime Maximum Benefit. UR Notification required or penalty applies.
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	100% of Allowable Claim Limits $250 Copay applies per day	UR Notification required for Inpatient or penalty applies.

LEVEL II BENEFITS – Payment Levels and Limits:

This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred ProviderOrganization (PPO) network.** Non-PPO Covered Charges are subject to Usual and Customary and Reasonable fees.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network). The "Level II PPO Benefit" also applies in the following exceptions:

1. If a Covered Person has no choice of PPO Providers in the specialty that the Covered Person is seeking within the PPO service area;
2. If a Medical Emergency or initial treatment of an Accidental Injury requires immediate care, and services are rendered by Non-PPO Providers; or
3. If a Covered Person receives Medically Necessary services from a Non-PPO Provider because the Covered Person is living or traveling outside of the geographic zip code area serviced by the PPO (Out- of-Area).

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Physician Services			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Maximum Benefits, Limits & Provisions**
Physician Medical Hospital Visits/Surgeon	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
Radiologist, Pathologist, Emergency Room Physician, On-call Specialist Physician, Anesthesiologist, Assistant Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits; PPO Deductible and Out-of-Pocket apply	

Outpatient Surgery - Surgeon - Radiologist, Pathologist, Anesthesiologist, Assistant Surgeon	80% of PPO rate Deductible waived 80% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible waived 80% of Usual and Customary fees Deductible waived PPO Out-of-Pocket applies	
Maternity (Including prenatal care, delivery and postnatal care.) Office Visit Copay does not apply after initial visit.	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of baby's discharge)	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Baby must be added as a Dependent within thirty-one (31) days of birth to be eligible for this benefit unless coverage for Dependent Children is in force.

Physician Services			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Maximum Benefits, Limits & Provisions**
***Lab and X-ray Independent Provider**	100% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible applies	
KIS Imaging Radiological Benefit (CT scans, MRIs and PET scans)	100% of KIS Imaging negotiated rate Deductible and Copay waived Call 888-458-8746 to schedule		UR Notification required or penalty applies.
***Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	UR Notification required or penalty applies.
All Covered Physician Office Expenses Including: • Office Visit • Lab and X-rays (except Select Diagnostic Medical Procedures) • Allergy serum/ injections • Voluntary Second or Third Opinion (exam) • Injections	PCP: 100% of PPO rate after $20 Copay Deductible waived Specialist: 80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
NOTE: For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.			
Office Surgery	80% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible waived	

***Sterilization Procedures**	80% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible waived	
Allergy Testing	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/*Group Therapy/ *Psychological Testing	100% of PPO rate after $20 Copay Deductible waived	60% of Usual and Customary fees Deductible applies	
Chiropractic Services (Including x-rays)	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
Urgent Care Facility (Minor Emergency Medical Clinic)	100% of PPO rate after $20 Copay Deductible waived	100% of Usual and Customary fees after $75 Copay; Deductible waived	
All Other Covered Physician Services	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	

Other Covered Services			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Maximum Benefits, Limits & Provisions**
***Therapy Services** • Physical • Occupational • Speech • Cardiac Rehabilitation • Pulmonary Rehabilitation	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Limited to thirty (30) visits per Calendar Year for Physical Therapy. UR Notification required or penalty applies.
***Chemotherapy/ Radiation Therapy/ Infusion Therapy** Wig (provided for hair loss during Chemotherapy/ Radiation Therapy)	80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies 60% of Usual and Customary fees Deductible applies	UR Notification required or penalty applies. Limited to one (1) wig per Lifetime.
***Durable Medical Equipment/Medical Supplies**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	UR Notification required for DME purchases over $500 and all DME rentals or penalty applies.
***Prosthetics/Orthotics**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	UR Notification required or penalty applies.
***Home Health Care Services**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Limited to one hundred thirty (130) visits per Calendar Year. UR Notification required or penalty applies.
***Home Infusion Therapy**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	UR Notification required or penalty applies.

***Private Duty Nursing**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Covered only if Hospital has no Intensive Care Unit (ICU) or ICU is full.
***Hospice**	80% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible waived	Limited to $10,000 Lifetime Maximum Benefit. UR Notification required for Inpatient Hospice or penalty applies. For Homebound Hospice contact Utilization Review for Coordination of Care.
Bereavement Counseling	80% of PPO rate Deductible waived	60% of Usual and Customary fees Deductible waived	Bereavement counseling not subject to Hospice Lifetime Maximum.

Other Covered Services			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Maximum Benefits, Limits & Provisions**
Diabetic Self-Management Training	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
***Temporomandibular Joint (TMJ) Syndrome**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	Limited to $750 Lifetime Maximum Benefit for Outpatient and $3,000 Lifetime Maximum for Inpatient.
Sleep Disorders **Office Visit** (exam only) *****Covered Services (Including sleep studies/ diagnostic testing, Surgery, devices and equipment)	PCP: 100% after $20 Copay; Deductible waived Specialist: 80% of PPO rate; Deductible applies 80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	
***Ambulance — Air or Ground Transportation**	80% of PPO rate Deductible applies	80% of Usual and Customary fees PPO Deductible and Out-of-Pocket apply	
Teladoc Telephone Consultation	100% after $10 Copay Deductible waived		
***All Other Covered Expenses**	80% of PPO rate Deductible applies	60% of Usual and Customary fees Deductible applies	

*** If these services are rendered by Provider's billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Limits & Provisions**

All Covered Wellness Benefits	100% of PPO rate Copay and Deductible waived	100% of Usual and Customary fees Deductible waived	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap smear and other routine lab
4. Annual Mammogram (routine)
5. Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. Routine Colonoscopy
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Company's OrganTransplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

ORGAN TRANSPLANT POLICY

Organ and tissue transplant coverage is provided under a separate insurance policy by Tokio Marine HCC – Stop Loss Group (TMHCC) and is issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this Major Medical Plan. Please contactTMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplantservices, and transplant network Provider access.

Pre-Authorization of Transplant Services

Pre-authorization of transplant services is required prior to seeing a transplant Provider for a consult and/orevaluation. Failure to do so could result in reduced benefits.

NOTICE - Transplant Network

In order to obtain 100% in-network benefits, you must use Providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network Provider that are not covered by the TMHCC policy are subject to this Medical Plan's benefits and the payment terms and conditions of the transplant network Provider's contracted rates.

For more information, contact your Medical Plan Administrator and/or human resources department.

NOTE: The Company's fully insured Organ Transplant Policy is the Primary payer for Organ, Tissue and Bone

Marrow Transplants. In the event the Company's Organ Transplant Policy does not cover some or all transplant related charges incurred by a Covered Person due to a pre-existing condition exclusion limitation, this Plan will consider the charges based on benefits below as the Secondary payer. See Coordination with Organ Transplant Policy section of this Plan Document.

Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	80% of Program rate Deductible applies	60% of Usual and Customary fees Deductible applies	UR Notification required for a transplant procedure or penalty applies. Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	80% of Program rate Deductible applies	60% of Usual and Customary fees Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging Limited to $10,000 Maximum Benefit per Transplant.

PRESCRIPTION DRUG PLAN BENEFITS

Prescription Drug Copays apply to satisfy the Annual Out-of-Pocket Maximum. After the Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.

Calendar Year Prescription Drug Deductible Per Covered Person	 $50
Prescription Card Service Supply Limit Generic Drugs Brand Name Drugs	**100% after applicable Copay** 34 days 20% Copay with a minimum of $5 and maximum of $100 20% Copay with a minimum of $20 and maximum of $100
Mail Order Service Supply Limit Generic Drugs Brand Name Drugs	**100% after applicable Copay** 90 days 20% Copay with a minimum of $5 and maximum of $100 20% Copay with a minimum of $40 and maximum of $100

Specialty Drugs*	**100% after applicable Copay**
Supply Limit	30 days
Generic Drugs	20% Copay with a minimum of $5 and maximum of $100
Brand Name Drugs	20% Copay with a minimum of $20 and maximum of $100

*Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.

NOTE: Medications required for Preventive Care services may be covered at 100% with no Copay.

The Prescription Drug Deductible must be satisfied each Calendar Year before Copays apply. The Prescription Drug Deductible and Copays are waived for Drugs prescribed for the following chronic healthconditions including diabetes, asthma, cardiovascular disease, hypertension (high blood pressure) and hyperlipidemia (high cholesterol).