GROUP BENEFITS

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE

THE HARTFORD

PREMIUM PLUS PLAN

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Calendar Year Deductible: $0 **Lifetime Maximum: Unlimited**

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
HOSPITALIZATION [2] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but the Part A Deductible	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but 25% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but 50% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but 12.5% of Medicare Part A Deductible per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM PLUS PLAN

THE HARTFORD

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEDUCTIBLE – **Hospital Confinement and Out-Patient Medical Expenses** When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible	$0	100% of Medicare Part B Deductible	**$0**
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	**$0**

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM PLUS PLAN

THE HARTFORD

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after $250 Deductible (to a lifetime maximum of $50,000)	**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM PLUS PLAN

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PRIVATE DUTY NURSING Service provided to a person while covered under this benefit and charged directly to the covered person by the nurse and not the hospital			
Up to a maximum of 3 shifts per day consisting of at least 3 consecutive hours of nursing care per shift	$0	100% of remaining covered expenses incurred after the copayment for 30 shifts per calendar year up to the benefit maximum of $500 per calendar year	**$20 copay per shift** (to a calendar year maximum of $500, then 100% thereafter)

[1] This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Please note this policy also may cover certain benefits mandated by the state where the employer is situsedor the state where you reside. Refer to your certificate for a description of any additional benefits.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

Benefit Overview

Express Scripts Medicare® (PDP)

YOUR 2022 PRESCRIPTION DRUG PLAN BENEFIT:

Orthodox Health Plans

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service. For maintenance medications, you have the choice of filling prescriptions for more than a one-month supply at pharmacies with preferred cost-sharing, including CVS and select retail pharmacies. These pharmacies may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network.

Deductible stage	You do not pay a yearly deductible				
Initial Coverage stage	You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,430:				
	Tier	**Retail One Month (31-day) Supply**	**Retail Two Month (32-60-day) Supply**	**Retail Three Month (90-day) Supply**	**Home Delivery Three Month (90-day) Supply**
	Tier 1: **Preferred Generic**	$5 Copayment	$10 Copayment	**Preferred cost-sharing** $8 Copayment **Standard cost-sharing** $15 Copayment	$8 Copayment
	Tier 2: **Generic Drug**	$10 Copayment	$20 Copayment	**Preferred cost-sharing** $15 Copayment **Standard cost-sharing** $30 Copayment	$15 Copayment
	Tier 3: **Preferred Brand Drugs**	$25 Copayment	$50 Copayment	**Preferred cost-sharing** $56 Copayment **Standard cost-sharing** $75 Copayment	$56 Copayment

	Tier 4: **Non-Preferred Drugs**	$60 Copayment	$120 Copayment	**Preferred cost-sharing** $165 Copayment **Standard cost-sharing** $180 Copayment	$165 Copayment
	Tier 5: **Specialty Tier Drugs**	$60 Copayment	$120 Copayment	**Preferred cost-sharing** $165 Copayment **Standard cost-sharing** $180 Copayment	$165 Copayment
	If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive. *Your cost-sharing amount may differ from the information shown in this chart if you use a home delivery pharmacy other than Express Scripts Pharmacy. Other pharmacies are available in our network. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy[SM]. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. If you have any questions about this coverage, please contact the Retiree Customer Service Center at 1.800.236.4782 Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.				
Coverage Gap stage	After your total yearly drug costs reach $4,430, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.				
Catastrophic Coverage stage	After your yearly out-of-pocket drug costs reach $7,050, you will pay **the greater of 5% coinsurance or:** • a $3.95 copayment for covered generic drugs (including drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage. • a $9.85 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.				

IMPORTANT PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **express-scripts.com/pharmacies**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- Beginning October 15, 2021, you can access your plan's 2022 list of covered drugs by visiting our website at **express-scripts.com/documents**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.
- When you use your Part D prescription drug benefits, Express Scripts Medicare sends you an *Explanation of Benefits* (Part D EOB), or summary, to help you understand and keep track of your benefits. You may also be able to receive a copy electronically by visiting our website, **express-scripts.com**, or by contacting the Retiree Customer Service Center at 1.800.236.4782 Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

This information is not a complete description of benefits. Call Customer Service at the numbers listed above for more information.

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

Other pharmacies are available in our network.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.