SUMMARY OF BENEFITS

L & E BOTTLING CO., INC.
HEALTH CARE BENEFITS PLAN

EFFECTIVE NOVEMBER 1, 2024

TPSC GROUP # 45960

MEDICAL SUMMARY OF BENEFITS

This summary is provided as a highlight of your health care plan benefits available to eligible Employees. If you have questions about your coverage, see your Summary Plan Description (SPD) or contact TPSC Member Services at (800) 426-9786.

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATION	Services from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	
PRE-CERTIFICATION	Certain Inpatient Admissions require Pre-Certification. *For details, see your Summary Plan Description (SPD).*	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	**NON-PREFERRED PROVIDER**
DEDUCTIBLE—*Applies to all services unless otherwise noted; excludes Copays.* ***EXCEPTION:*** *Out-of-pocket expenses for allowable Deductibles on Non-Preferred Provider Ambulance and Emergency Room services will apply to the Preferred Provider Deductible.*		
Scenario #1—	**$200** Individual/**$600** Family per Calendar Year	
To qualify for Scenario #1 Deductible, Employees (and Covered Spouses) must have: **a)** been covered on this Plan during November & December of the prior Calendar Year **AND b)** completed the Health Assessment from American Health Holding during that time. *Children are not required to complete a Health Assessment, but their Deductible will be the same as their parent(s).*		
Scenario #2—	**$400** Individual/**$1,200** Family per Calendar Year	
The Scenario #2 Deductible applies if an Employee (and a Covered Spouse) takes no Health Assessment from American Health Holding.		
Scenario #3—	**$300** Individual/**$900** Family per Calendar Year	
The Scenario #3 Deductible applies for the first Calendar Year in which the Employee (and Family) is covered by the Plan.		
OUT-OF-POCKET MAXIMUM—*Benefits are increased to 100% payment if Out-of-Pocket expenses for Copays and Coinsurance reach these amounts. Deductibles and expenses Incurred from Weight Loss Management, Alternative Housing Facilities, and non-covered services do not apply to the Preferred Provider Out-of-Pocket Maximum.*	**$2,500** Individual/**$5,000** Family per Calendar Year	**Unlimited.** *Services from Non-Preferred Providers do not apply to the Out-of-Pocket Maximum.*
EXCEPTION: *Out-of-pocket expenses for allowable Copays and Coinsurance on Non-Preferred Provider Ambulance and Emergency Room services will apply to the Preferred Provider Out-of-Pocket Maximum.*		
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
Inpatient		
Hospital Visit	Paid at 80%	Paid at 60%
Surgery	Paid at 80%	Paid at 60%
Outpatient		
Office Visit/Urgent Care	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
Outpatient/Office Surgery	Paid at 80%	Paid at 60%
Second Surgical Opinion	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 60%
II. PREVENTIVE CARE SERVICES—*For a list of Preventive Care Services, see http://tpscbenefits.com/preventive-care-services*		
All Preventive Care Services	**Deductible Waived,** Paid at 100%	**Deductible Waived,** Paid at 100%
III. HOSPITAL SERVICES		
Inpatient		
Room and Board	Paid at 80%	Paid at 60%
Intensive Care & Coronary Care Units	Paid at 80%	Paid at 60%
Hospital Miscellaneous Expenses	Paid at 80%	Paid at 60%
Outpatient		
Outpatient Department/ Ambulatory Surgical Center	Paid at 80%	Paid at 60%
Emergency Room	**$75 Copay*** then:	**$75 Copay*** then:
Services and Supplies	Paid at 80%	Paid at 80%
X-ray and Lab	Paid at 80%	Paid at 80%

*** Emergency Room Copay is waived if patient is admitted as an Inpatient.**

MEDICAL SUMMARY OF BENEFITS *(continued)*

PRIMARY BENEFITS *(cont'd)*	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
IV. DIAGNOSTIC SERVICES—*Including interpretations; non-routine/non-preventive scans, imaging and labs; non-routine cancer screenings.*		
Physician Services	Paid at 80%	Paid at 60%
Inpatient/Outpatient Facility Services	Paid at 80%	Paid at 60%
V. MATERNITY CARE		
First Office Visit Only	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
Professional Services	Paid at 80%	Paid at 60%
Hospital/Birthing Center Facility Services	Paid at 80%	Paid at 60%
VI. MENTAL HEALTH & SUBSTANCE USE DISORDER CARE		
Inpatient Facility/Physician Services	Paid at 80%	Paid at 60%
Outpatient Facility Services	Paid at 80%	Paid at 60%
Outpatient Physician Services	**Deductible Waived, $10** Copay	**Deductible Waived,** Paid at 60%
VII. HOME HEALTH CARE *Limited to 130 visits per Calendar Year.*	Paid at 80%	Paid at 60%
VIII. HOSPICE—*Limited to six (6) months of care, including 60 days Inpatient care, per Lifetime.*	Paid at 80%	Paid at 60%
IX. OUTPATIENT PRESCRIPTION DRUGS *****Deductible Waived*****		
	EXPRESS SCRIPTS PHARMACIES	**NON-MEMBER PHARMACIES***
Retail—*Limited to a 34-day supply.*		
Generic Drug Copay	10% (of drug cost)	15% (of drug cost)* *plus **$9** handling fee*
Formulary Brand Name Drug Copay	30% (of drug cost)	35% (of drug cost)* *plus **$9** handling fee*
Non-Formulary Brand Name Drug Copay	40% (of drug cost)	45% (of drug cost)* *plus **$9** handling fee*
Mail-Order—*Limited to a 100-day supply.*	***COSTS THE LESSER OF:***	
Generic Drug Copay	10% (of drug cost) or **$15** Copay	Not Available
Formulary Brand Name Drug Copay	30% (of drug cost) or **$90** Copay	
Non-Formulary Brand Name Drug Copay	40% (of drug cost) or **$130** Copay	
Specialty Medications—*Limited to a 100-day supply; only first fill at pharmacy, then mail-order through ESI's Specialty Pharmacy.*		
	COSTS THE LESSER OF:	
Generic Drug Copay	10% (of drug cost) or **$15** Copay	Not Available
Formulary Brand Name Drug Copay	30% (of drug cost) or **$90** Copay	
Non-Formulary Brand Name Drug Copay	40% (of drug cost) or **$130** Copay	
	**Limited to ESI's Maximum Allowable Charge. Must pay 100% of cost at purchase, and submit claim directly to ESI for reimbursement. Handling fee is not covered by the Plan.*	
X. SKILLED NURSING FACILITY *Limited to 180 days for same or related condition.*	Paid at 80%	Paid at 60% up to **$100** per day
XI. TRANSPLANTS—*See your SPD for details.*	Paid at 80%	Paid at 60%
XII. OTHER BENEFITS		
Acupuncture Services *Limited to twenty (20) visits per Calendar Year.*	**Deductible Waived, $25** Copay	Not Covered
Ambulance	Paid at 80%	Paid at 80%
Cardiac & Pulmonary Rehabilitation *Limited to three (3) visits each per Calendar Year.*	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
Cochlear Implants	Paid at 80%	Paid at 60%
Diabetic Education & Training	Paid at 80%	Paid at 60%
Durable Medical Equipment (DME), Medical Supplies, Prosthetic & Orthopedic Appliances *Pre-authorization required for equipment over **$2,000** purchase price or **$500** per month rental fee.*	Paid at 80%	Paid at 60%
Hearing Aids—*Limited to **$1,000** per ear per three (3) consecutive Calendar Years.*	Paid at 80%	Paid at 60%

MEDICAL SUMMARY OF BENEFITS *(continued)*

XII. OTHER BENEFITS *(cont'd)*	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Housing Allowance—*Limited to seventy (70) days per Calendar Year for same or related condition.*	Paid at 80%, up to **$60** per day	
Inpatient Rehabilitation	Paid at 80%	Paid at 60%
Jaw Treatment—*Includes TMJ and MPD. Limited to $6,000 per Lifetime.*	Paid at 80%	Paid at 60%
Manipulations & Related Modalities *Limited to twenty (20) visits per Calendar Year.*	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
Nutritional Counseling	Paid at 80%	Paid at 60%
Outpatient Dialysis Treatment ***** Deductibles, Copays, and Coinsurance waived. *****	Paid at 100%	*See your SPD for coverage details at a Non-Preferred Provider.*[1]
Outpatient Habilitative Services—*Includes Occupational, Physical, & Speech Therapies. Limited to sixty (60) visits per Calendar Year for all modalities combined.*	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
Outpatient Rehabilitation—*Includes Massage, Occupational, Physical, & Speech Therapies. Limited to sixty (60) visits per Calendar Year for all modalities combined.*	**Deductible Waived, $25** Copay	**Deductible Waived,** Paid at 60%
PKU	Paid at 80%	Paid at 60%
Sleep Disorder Treatment	Paid at 80%	Paid at 60%
Vision Therapy *Limited to sixty (60) visits per Lifetime.*	Paid at 80%	Paid at 60%
Weight Loss Management for Morbid Obesity *See section XI. OTHER BENEFITS in your SPD.*	**Deductible Waived,** Paid at 80%	**Deductible Waived,** Paid at 60%
Eligible Non-Listed Services	Paid at 80%	Paid at 60%

[1] *See* subsection XII. OTHER BENEFITS, paragraph "**Outpatient Dialysis Treatment"** in your SPD for additional details about cost sharing for services and supplies. Services from a Non-Preferred Provider are subject to the **Outpatient Dialysis Program** described in the **DEFINITIONS** section of your SPD.

VISION SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATION	All services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
LIFETIME MAXIMUM BENEFIT	Unlimited
ANNUAL MAXIMUM BENEFIT	As shown below.
DEDUCTIBLE	None

BENEFITS	
ROUTINE VISION EXAM *Limited to one (1) Exam per Year.*	Paid at 100%
HARDWARE	
First Pair of Glasses	
Lenses—*Limited to two (2) lenses per Calendar Year.*[2]	Paid at 100%
Frames—*Limited to one pair per two (2) Calendar Years.*	Paid at 100%
Elective Contact Lenses—*Limited to one pair*[3] *per Calendar Year. Covered in lieu of eyeglasses; includes Fitting & Evaluation.*	
Ages 18 and Younger	Paid at 100%
Ages 19 and Older	Paid at 100%, up to **$150** per Calendar Year
Low Vision Contact Lenses *Limited to one pair per two (2) Calendar Years.*	Paid at 100%
Second Pair of Glasses	**$10** Copay, then
Lenses—*Limited to two (2) lenses per Year.*[1]	Paid at 100%
Frames—*Limited to one pair per two (2) Calendar Years.*	Paid at 100%
Elective Contact Lenses—*Limited to one pair*[2] *per Calendar Year. Covered in lieu of eyeglasses; includes Fitting & Evaluation.*	
Ages 18 and Younger	Paid at 100%
Ages 19 and Older	Paid at 100%, up to **$150** per Calendar Year
Low Vision Contact Lenses *Limited to one (1) pair per two (2) Calendar Years.*	Paid at 100%

[2] Covered Lenses include single vision, bifocal, trifocal, and lenticular lenses. Special Features are covered. However, the Plan will cover standard grades of photochromatic light-sensitive plastic lenses (such as transitions), progressive lenses (no-line bifocal), anti-reflective coating and scratch coating. The Covered Person is responsible for any cost that exceeds a standard grade feature.

[3] Disposable contact lenses are eligible, but limited to a one-Calendar Year Supply.

DENTAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATION *See new Cigna Dental PPO passive network below.*	All services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
ANNUAL MAXIMUM BENEFIT—*Class I, II, & III services for Children under age 19 are not included.*	**$1,800** Individual per Calendar Year[4]
LIFETIME MAXIMUM BENEFIT	**Class IV Non-Medically Necessary Orthodontia** *Limited to $1,800 per lifetime.* **Class IV Medically Necessary Orthodontia** *Limited to one (1) comprehensive treatment per lifetime.* **Dental Care Following Radiation Treatment** *Limited to $10,000 per Lifetime.*
DEDUCTIBLE	None

DENTAL BENEFITS

Class I	**Class II**	**Class III**	**Class IV**		
Preventive & Diagnostic Services	**Basic Services**	**Major Services**	**Non-Medically Necessary Orthodontia**	**Medically Necessary Orthodontia**	**Dental Care After Radiation Treatment**
Paid at 100%	Paid at 90%	Paid at 75%	Paid at 70%	Paid at 70%	Paid at 100%
Cleanings	Endodontics	Crowns	*Limited to dependent Children under age 19 and once per Lifetime. Treatment must be completed within 12 months.*	*Limited to dependent Children under age 19 and once per Lifetime. Treatment must be completed within 30 months.*	*Treatment for deterioration of teeth and gum due to radiation therapy for cancer in the head, neck or throat.*
Exams	Extractions	Fixed Bridgework			
Fluoride	Fillings	Implants			
Sealants	General Anesthesia	Onlays			
X-rays	Night-guards	Dentures			
	Oral Surgery	Replacement of Appliances			
	Stainless Steel Crowns				

Cigna Dental PPO SA Plus. *Your dental plan now offers a "passive network" of dental providers through Cigna Dental PPO Shared Administration Plus (Cigna Dental PPO SA Plus). A passive network doesn't require you to see a provider in that network. You may still select any licensed dentist of your choice.*

If you choose to use a dental provider in the passive network, you will receive the benefit of preferred pricing agreements and lower out-of-pocket expenses … and help your dental plan dollars go further.

For a directory of Cigna Dental providers, see https://www.cigna.com/hcpdirectory/

[4] **Dental Accidental Injury:** The Plan will pay 100% of a Covered Person's dental Covered Expenses incurred as a direct result of an Accidental Bodily Injury, up to any unused Calendar Year maximum benefit.