

TIFFIN MOTORHOMES, INC. ALLEGRO HEALTH PLAN

SCHEDULE OF BENEFITS

EFFECTIVE MARCH 1, 2019

All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the Summary Plan Description (SPD) including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Appropriate; and that services, supplies and care are not Experimental and/or Investigational.

Verification of Eligibility: Toll Free (outside Birmingham, Alabama area) 800-451-4318 or local (Birmingham, Alabama) 205-871-3229 or go to www.yourtpa.com. Call this number to verify eligibility for Plan benefits before the charge is incurred.

Precertification through the utilization management organization is required prior to services being rendered for specific services listed below. Although not required for childbirth as outlined by Federal Legislation, pre-notification is recommended and penalty for failure to pre-notify a hospitalization may apply should a hospitalization result in an extended stay beyond that mandated by Federal Legislation.

Services Requiring Precertification:

Inpatient Hospital Admissions – Medical and Mental Health/Substance Abuse
Outpatient Hospital Services, Testing – Mental Health/Substance Abuse

Utilization Management Organization (Medical):

Bay Care Management
1-866-966-9221

Utilization Management Organization (Mental Health/Substance Abuse):

American Behavioral
1-800-677-4544

Providers:

1. **Tier 1 Health Link Select** Hospitals include North Mississippi Medical Center (NMMC) – Tupelo, North Mississippi Medical Center - Iuka, North Mississippi Medical Center – Hamilton, Magnolia Regional, Amory Regional and Gilmore Memorial Hospital. Tier 1 Physicians include NAMCI physicians and Health Link physicians. Health Link providers in Tennessee and Alabama as well as other Health Link hospital and facility providers in Mississippi not listed above are considered Tier 3 Providers.

Tier 1 NAMCI Select Hospitals include Eliza Coffee Memorial, Russellville Hospital, Northwest Medical Center, Vanderbilt, and Huntsville Hospital and its affiliated hospitals including Helen Keller, Red Bay, Decatur Morgan, Madison, Athens Limestone and Lawrence Medical Center.

2. **Tier 2 Non-Select NAMCI** Hospitals and facilities (those **NAMCI** hospitals not in the **NAMCI** Select Network) with the exception of University of Alabama Hospital, Kirklin Clinic, and the Children's Hospital of Alabama.

Tier 2 Health Choice Providers

3. **Tier 3 Out-of-Network Providers** – All providers not listed above. University of Alabama Hospital, Kirklin Clinic and Children's Hospital of Alabama are out-of-network Providers. Other Health Link hospital and facility providers in Mississippi not listed as Tier 1 Providers are considered Tier 3. All Health Link providers in Tennessee and Alabama are considered Tier 3 Providers.

| BENEFIT | TIER 1 | TIER 2 | TIER 3 |
|--|---|--|--|
| SUMMARY OF COST SHARING Eligible expenses applied to the Tier 1 Calendar Year Deductible will NOT be applied to the Tier 2 or Tier 3 Calendar Year Deductible and Eligible expenses applied to the Tier 1 Calendar Year Out-of-Pocket Maximum will NOT apply to the Tier 2 Out-of-Pocket Maximum | | | |
| Calendar Year Deductible | \$350 individual; 3 member family maximum | \$700 individual; 3 member family maximum deductible | |
| Calendar Year Out-of-Pocket Maximum – includes all deductibles, copays (with the exception of RX copays) and coinsurance | \$2,500 individual, \$5,000 aggregate maximum per family | \$2,500 individual, \$5,000 aggregate maximum per family | There is no out-of-pocket maximum for out-of-network services |
| INPATIENT HOSPITAL | | | |
| Preadmission Certification required for all Inpatient admissions (except maternity); notification within 48 hours of emergencies. | | | |
| | TIER 1 HEALTH LINK SELECT FACILITY PROVIDERS, NAMCI SELECT (AL) FACILITY PROVIDERS | TIER 2 NON-SELECT NAMCI FACILITY PROVIDERS AND HEALTH CHOICE PROVIDERS | TIER 3 OUT-OF-NETWORK PROVIDERS |
| Inpatient Hospital Note: Inpatient hospital deductibles and copays do apply to the Calendar Year Out-of-Pocket Maximum | Covered at 100% after \$600 per admission deductible; \$175 per day hospital copay days 2-11 for each admission | Covered at 75% after \$750 per admission deductible | Covered at 65% after \$1,200 per admission deductible |
| OUTPATIENT HOSPITAL BENEFITS | | | |
| | TIER 1 HEALTH LINK SELECT FACILITY PROVIDERS, NAMCI SELECT (AL) FACILITY PROVIDERS | TIER 2 NON-SELECT NAMCI FACILITY PROVIDERS AND HEALTH CHOICE PROVIDERS | TIER 3 OUT-OF-NETWORK PROVIDERS |
| Outpatient Surgery (including Ambulatory Surgical Centers) | Covered at 100% after \$600 hospital copay | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Dialysis, IV Therapy, Chemotherapy & Radiation Therapy | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Emergency Room (Medical Emergency) | Covered at 100% after \$175 hospital copay | Covered at 100% after \$175 hospital copay | Covered at 100% after \$175 hospital copay |
| Emergency Room (Accident) | Covered at 100% after \$175 hospital copay | Covered at 100% after \$175 hospital copay for services within 72 hours, thereafter 75% subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the Plan | Covered at 100% after \$175 hospital copay for services within 72 hours, thereafter 65% subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the Plan |
| Emergency Room – (non-medical emergency including diagnostic xray, lab, tests associated with emergency room) | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |

| | | | |
|---|--|--|--|
| All Other Emergency Room Services – accident and medical emergency | Covered at 100%; no copay or deductible | Covered at 100%; no copay or deductible | Covered at 100%; no copay or deductible |
| Outpatient Diagnostic Lab, X-ray & Pathology | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Outpatient Hospital Services or Supplies not listed above and not listed in the section of this schedule called Benefits for Other Covered Services | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| PHYSICIAN BENEFITS | | | |
| | TIER 1 HEALTH LINK NON-FACILITY PROVIDERS AND NAMCI NON-FACILITY PROVIDERS | TIER 2 HEALTH CHOICE PROVIDERS | TIER 3 OUT-OF-NETWORK PROVIDERS |
| Office Visits and Consultations | Covered at 100% after \$40 primary physician copay or \$60 specialist copay with no deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Inpatient Physician Visits and Consultations | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Emergency Room Physician | Covered at 100% after \$60 physician copay | Covered at 100% after \$60 physician copay | Covered at 100% after \$60 physician copay |
| Surgery & Anesthesia | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Maternity Care | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| PREVENTATIVE CARE | | | |
| Routine Newborn (in hospital) | Covered at 100%; no copay or deductible | Not covered | Not covered |
| Routine Immunizations and Preventative Services – limited to immunizations and preventative services required to be covered under the Affordable Care Act – see www.yourtpa.com | Covered at 100%; no copay or deductible | Not covered | Not covered |
| BENEFITS FOR OTHER COVERED SERVICES | | | |
| Allergy Testing and Treatment | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Ambulance Services | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Chiropractic Services Limited to 30 visits per calendar year | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Dialysis services at a renal dialysis facility | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |

| | | | |
|--|---|---|--|
| Durable Medical Equipment (DME) | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Occupational Therapy – rehabilitative and habilitative Limited to certain services related to hand and lymphedema | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Physical Therapy - rehabilitative and habilitative | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| TMJ - Phase 1 Therapy | Covered at 80% subject to calendar year deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| Impacted Teeth and Tumors | Covered at 100%; no copay or deductible | Covered at 75% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| HOME HEALTH AND HOSPICE BENEFITS | | | |
| Home Health and Hospice | Covered at 100%; no copay or deductible | Covered at 80% subject to calendar year deductible | Covered at 65% subject to calendar year deductible |
| BENEFITS FOR MENTAL NERVOUS/SUBSTANCE USE CONDITIONS ALL INPATIENT TREATMENT MUST BE AUTHORIZED BY AMERICAN BEHAVIORAL OR THERE WILL BE NO BENEFIT. TIFFIN MOTORHOMES, INC. URGES ALL PARTICIPANTS TO UTILIZE THE SERVICES OF AMERICAN BEHAVIORAL TO MANAGE THEIR MENTAL HEALTH AND SUBSTANCE USE DISORDER CONDITIONS SO THAT THEY CAN HAVE ACCESS TO THE BEST POSSIBLE TREATMENT AND ALSO MANAGE OUT-OF-POCKET COSTS. ALLOWABLE AMOUNTS DETERMINED BY AMERICAN BEHAVIORAL USING FEE SCHEDULES AND/OR PER DIEM RATES. PLEASE CONTACT AMERICAN BEHAVIORAL AT 800-677-4544. | | | |
| | In-Network American Behavioral | Out-of-Network American Behavioral | |
| Outpatient Office Visits | \$40 copay and then 100% per visit/session/group therapy session | 65% after calendar year deductible | |
| Ambulatory Detoxification | | | |
| Psychological/Neuropsychological Testing * | \$40 copay and then 100% per visit/session/group therapy session | 65% after calendar year deductible | |
| Acute Inpatient Hospitalization | | | |
| Acute Inpatient Detoxification | Covered at 100% after \$600 per admission deductible; \$175 per day hospital copay days 2-11 for each admission | Covered at 65% after \$1,200 per admission deductible | |
| Inpatient Electroconvulsive Therapy (ECT) * | | | |
| Inpatient Physician Services | 100% | 65% after calendar year deductible | |
| Partial Hospitalization/Day Treatment Program (PHP) | \$60 copay and then 100% per visit/session/group therapy session | 65% after calendar year deductible | |
| Intensive Outpatient Program (IOP) | | | |
| Electroconvulsive Therapy (ECT) * | | | |
| Anesthesia (in conjunction with ECT) | 100% | 65% after calendar year deductible | |
| Ambulance Services | | | |
| Emergency Department | Covered by Medical Plan | Covered by Medical Plan | |
| Imaging | | | |
| Lab Work | | | |

- Psychological/Neurological Testing, Inpatient Services, Outpatient Hospital Services require precertification. Please call American Behavioral at 800-677-4544

| PRESCRIPTION DRUGS | | |
|---|--|-------------------|
| | With the Tiffin Motorhomes, Inc. Drug Card | Without Drug Card |
| Prescription Drug Out-of-Pocket Maximum Per Calendar Year | \$4,650 per individual \$9,300 aggregate per family | |
| Retail Prescription Drugs: up to 30 day supply at Super Pharmacies - Redmont Pharmacy, Family Pharmacy of Russellville, Hometown Pharmacy, Family Pharmacy of Littleville, Winfield Drugs, Belmont Pharmacy, Medical Plaza on Harper, Gatlin's Pharmacy, Fred's Pharmacies outside state of Alabama and Belmont, MS <ul style="list-style-type: none"> • Tier 1 – Generic \$6 copay • Tier 2 – Preferred \$35 copay • Tier 3 – Non-preferred \$60 copay | | |
| Retail Prescription Drugs: up to 30 day supply – all other pharmacies <ul style="list-style-type: none"> • Tier 1 – Generic \$12 copay • Tier 2 – Preferred \$40 copay • Tier 3 – Non-preferred \$60 copay | | Not covered |
| Mail Order Prescription Drugs: up to 30 day supply <ul style="list-style-type: none"> • Tier 1 – Generic \$12 copay • Tier 2 – Preferred \$40 copay • Tier 3 – Non-preferred \$60 copay | | Not covered |
| Mail Order Prescription Drugs: 31 – 90 day supply <ul style="list-style-type: none"> • Tier 1 – Generic \$30 copay • Tier 2 – Preferred \$105 copay • Tier 3 – Non-preferred \$150 copay | | Not covered |

NOTE: PRESCRIPTION DRUGS CLASSIFIED AS SPECIALTY RX ARE NOT COVERED EFFECTIVE MARCH 1, 2019

NOTE: COVERED SERVICES OBTAINED FROM A TIER 3 OUT-OF-NETWORK PROVIDER WILL BE COVERED AT THE TIER 1 OR TIER 2 BENEFIT LEVEL SUBJECT TO REASONABLE AND APPROPRIATE UNDER THE FOLLOWING CIRCUMSTANCES:

1. Treatment received while a Covered Participant is traveling or resides at least 50 miles outside the Tier 1 or Tier 2 PPO service areas will be covered at the Tier 2 benefit level. Dependents who are full-time or part-time college students and are attending schools at least 50 miles outside the Tier 1 or Tier 2 PPO service area and receive treatment more than 50 miles from the Tier 1 or Tier 2 PPO service area, the treatment will be covered at the Tier 1 benefit level.

2. Treatment received at a Tier 1 or Tier 2 facility by a Tier 3 out-of-network provider will be covered at the same Tier benefit level as the facility where treatment is received.
3. Services not offered by Tier 1 providers will be covered at the Tier 1 benefit level and limited to Reasonable and Appropriate.

TRANSPLANTS MUST BE PERFORMED AT A CENTER OF EXCELLENCE FACILITY. A Center of Excellence transplant facility is a facility that is designated by the Employer to be in the preferred provider transplant network or a facility that has agreed to requirements of the Plan that enable the facility to accept Plan provisions of a preferred provider for the specific transplant claimant. **NO BENEFITS ARE PAYABLE IF A TRANSPLANT IS RECEIVED AT A FACILITY THAT HAS NOT BEEN APPROVED AS A CENTER OF EXCELLENCE BY THE PLAN UNLESS PRIOR APPROVAL FOR SERVICES AT A NON-PARTICIPATING TRANSPLANT CENTER IS RECEIVED FROM THE PLAN SPONSOR.**