Prepared for: Rural Champaign County Special Education Cooperative, Participating Public Agency/Educational Institution of the Illinois Educators Risk Management Program Group Health Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2018

Illinois Educators Risk Management Program

GPCM20-IEspdruralchampcntySF-1119

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INTRODUCTION

This document is a description of the Illinois Educators Risk Management Program Group Health Plan (the Plan). No oral interpretations can change this Plan.

The Illinois Educators Risk Management Program Group Health Plan ("Plan") is a self-funded health benefit plan established to provide hospital, medical and Prescription Drug benefits for Employees and IMRF Participants of the public agencies/educational institutions named as a "participant" in the Illinois Educators Risk Management Program Association Intergovernmental Cooperation Agreement which comprises the Illinois Educators Risk Management Program Association.

Coverage under the Plan will take effect for an eligible Employee and his or her eligible Dependents when the Employee and such Dependents satisfy all eligibility and enrollment requirements of the Plan.

Failure to follow the eligibility and enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions and limitations in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, Preauthorization requirements, lack of Medical Necessity, untimely filing of claims or lack of coverage.

The Plan will provide benefits only for Eligible Expenses incurred while this coverage is in force. This Plan does not provide benefits for Eligible Expenses incurred before coverage began or after coverage terminates. An Eligible Expense for a service or supply is considered incurred on the date the service or supply is furnished.

Changes in the Plan may occur in any or all parts of the Plan including benefits, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or part.

The Plan Administrator/Plan Sponsor fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

If the Plan is terminated, amended or benefits are eliminated, the rights of Covered Persons are limited to Eligible Expenses incurred before termination, amendment or elimination.

This Plan Document/Summary Plan Description explains Plan rights and benefits for covered Employees, IMRF Participants and their covered Dependents on or after **January 1, 2018**. It is divided into the following sections:

- **NOTICES.** Explains important information to Covered Persons as may be required to be provided to the Plan by the Covered Person or by the Plan to the Covered Person.
- **HEALTH ALLIANCE MEDICAL POLICY.** Explains the terms of the Health Alliance Medical Policy and the criteria which must be met before Plan benefits are provided for some healthcare services under the Plan.
- **SCHEDULE OF BENEFITS.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services/benefits.
- **ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS.** Explains eligibility for coverage under the Plan, the enrollment requirements of the Plan, when Plan coverage takes effect and terminates and any extension of benefits available under the Plan.
- **MEDICAL BENEFITS.** Explains when a medical benefit applies and the types of expenses that are considered Eligible Expenses under the Plan.
- **PREAUTHORIZATION.** Explains the requirements for Preauthorization of Listed Services. **This should be read carefully since each Covered Person is required to take action to ensure that Listed Services have been Preauthorized; otherwise benefits available under the Plan may be reduced or expenses incurred may be considered excluded expenses.**

- **CASE MANAGEMENT.** Explains when alternative benefits, which are otherwise excluded or limited under the Plan, may be provided to Covered Persons.
- **DEFINED TERMS.** Defines Plan terms that have a specific meaning.
- **PLAN EXCLUSIONS.** Describes the types of expenses that are considered excluded expenses under the Plan.
- **PRESCRIPTION DRUG BENEFITS.** Explains when a Prescription Drug benefit applies and the types of Prescription Drug expenses that are considered Eligible Expenses and excluded expenses under the Plan.
- **HOW TO SUBMIT A CLAIM.** Explains the rules for filing claims and the claims review procedures.
- **CLAIMS DENIAL APPEAL PROCEDURE.** Explains the rules for requesting an appeal when a claim is wholly or partially denied.
- **COORDINATION OF BENEFITS.** Shows the Plan payment order when a person is covered under more than one plan.
- **THIRD PARTY RECOVERY PROVISION.** Explains the Plan's rights to recover payment of incurred expenses when a Covered Person has a claim against another person because of Injuries sustained.
- **MEDICARE-ELIGIBLE BENEFICIARIES.** Explains the federal Medicare Secondary Payer (MSP) provisions and limitations and how they may affect a person's coverage under the Plan.
- **CONTINUATION COVERAGE RIGHTS UNDER COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.
- **ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF) BENEFITS.** Explains the continuation option available to eligible Employees who retire or become disabled and immediately become entitled to receive an IMRF pension or disability benefit.
- **GENERAL PLAN ADMINISTRATION INFORMATION.** Explains the Plan's structure and responsibilities for administration of the Plan.
- **GENERAL PLAN INFORMATION.** Provides details about the Plan, including pertinent addresses and telephone numbers relative to administration of the Plan.

NOTICES

NON-ENGLISH LANGUAGE NOTICE

This Plan Document/Summary Plan Description contains, in English, a summary of a Covered Person's plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document/ Summary Plan Description, he or she may contact the Plan Administrator/Plan Sponsor at the telephone number or address specified in the "GENERAL PLAN INFORMATION" section of this document.

NOTIFICATION OF PLAN ADMINISTRATOR/PLAN SPONSOR

It is the Employee's responsibility to notify the Employer or Plan Administrator/Plan Sponsor within 31 days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit unless the Plan elsewhere specifically provides for a longer notice provision. The foregoing includes, but is not limited to, the following:

- Notifying the Plan Administrator/Plan Sponsor of an address change within 31 days of such change; and
- Notifying the Plan Administrator/Plan Sponsor of a name change within 31 days of such change.

GRANDFATHERED HEALTH PLAN STATUS

This Plan is not considered a "grandfathered" health plan under the Patient Protection and Affordable Care Act of 2010 ("PPACA," also commonly referred to as the "Affordable Care Act" or "Health Care Reform"). Non-grandfathered health plans must comply with certain consumer protections under the PPACA such as the elimination of lifetime limits on the dollar value of Essential Health Benefits and coverage of Dependent children to age 26.

CONFIDENTIAL COMMUNICATIONS

If this Plan's normal communication channels could endanger a Covered Person, the Covered Person (if a Dependent child or the parent or Legal Guardian acting on the child's behalf) has the right to request that the Plan send communications that contain the Covered Person's medical information by alternative means or to an alternative location. The Plan will ask the Covered Person the reason for his or her request, and the Plan will accommodate all reasonable requests to the extent the request specifies an alternative location and allows the Plan to continue to process claims.

CARDIOVASCULAR DISEASE

Because cardiovascular disease is a leading cause of death and disability, the Plan wants to remind adult Covered Persons of the importance and value of early detection and proactive management of cardiovascular disease.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT OF 1996 (NMHPA)

Under federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section, or require that a Provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, this provision generally does not prohibit the mother's or newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) and taking into consideration the availability of a post-discharge visit within 48 hours following the discharge, with either a Physician in his or her office or with a registered nurse (R.N.), or licensed practical nurse (L.P.N.) supervised by an R.N., in the child's home. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Under federal law, this Plan is required to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a balanced or symmetrical appearance; and
- Prostheses and treatment of physical complications in all stages of, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such benefits are subject to all other Plan terms and limitations.

PROVIDER NONDISCRIMINATION

To the extent that an item or service is considered an Eligible Expense under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a healthcare Provider who is acting within the scope of the Provider's license or other required credentials under applicable state law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, reasonable medical management requirements, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Preferred Provider.

HEALTH ALLIANCE MEDICAL POLICY

The Plan has adopted the terms of the Health Alliance Medical Policy ("Medical Policy"), which may be amended from time to time without notice. Healthcare services that are considered Eligible Expenses under the Plan are subject to all Plan provisions, limitations and requirements.

Benefits for healthcare service expenses will be provided only if the services provided are Medically Necessary and appropriate for the treatment, maintenance or improvement of your health. Some healthcare services are subject to Preauthorization and a determination that criteria have been met before expenses are incurred.

The Medical Policy has been developed as a guide for determining Medical Necessity. The Medical Policy provides the criteria which must be met before Plan benefits are provided for some healthcare services under the Plan. The Medical Policy is available on the Health Alliance website: HealthAlliance.org under "Authorizations" and "Medical Policies", or you can request a paper copy of a Medical Policy by contacting the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or as specified in the "GENERAL PLAN INFORMATION" section of this document.

To understand the benefits that are available under the Plan, call the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or as specified in the "GENERAL PLAN INFORMATION" section of this document to verify benefits and Preauthorization requirements prior to receiving services.

To keep pace with technology changes and your Plan's equitable access to safe and effective care, Health Alliance has established policies and procedures to evaluate new developments in medical technology and its applicability to the potential need for benefit modifications. Professionals with the expertise related to new medical procedures, pharmacological treatments and devices participate in the evaluation of each new technology and the creation of criteria for its applications.

The obligation of Health Alliance is limited to furnishing the Medical Policy for use by the Plan Administrator/Plan Sponsor. Health Alliance is not liable, in any event, for any act or omission of the professional personnel of any medical group, Hospital or other Provider of services to Covered Persons.

The Medical Policy does not replace or amend the Plan requirements or the discretionary authority of the Plan Administrator/Plan Sponsor. The Plan may use the Medical Policy to determine if, under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is Medically Necessary and appropriate. The conclusion that a procedure, drug, service or supply is Medically Necessary and appropriate does not constitute coverage. The Plan defines which procedure, drug, service or supply is subject to benefits, excluded, limited, or subject to additional requirements. In order to be eligible, all services must be Medically Necessary and appropriate and otherwise defined in the Plan. In all cases, final benefit determinations are based on the Plan terms. To the extent there are any conflicts between Medical Policy guidelines and applicable Plan benefits, the Plan shall prevail, subject to the Plan Administrator's/Plan Sponsor's discretionary authority. The Medical Policy is not intended to override the Plan which defines the Covered Person's benefits, nor is it intended to dictate to Providers how to practice medicine.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 500d PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$500	$1,000
Per Family Unit	$1,500	$3,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 500d PLAN OPTION

Deductibles apply to all eligible services/benefits except for the following:

- Ambulance services;
- Emergency Services;
- Urgent care;
- Spinal Manipulations; and
- The following services received from Preferred Providers:
  - Office visits;
  - Preventive care;
  - Well-child care;
  - Routine eye exams—Adult;
  - Routine eye exams—Pediatric;
  - Prescription Drugs; and
  - Specialty Prescription Drugs.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$3,000	$5,000
Per Family Unit	$6,500	$11,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	20% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

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ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Rehabilitation and Skilled Nursing Facility [1]	20% coinsurance, after deductible	50% coinsurance, after deductible
Human Organ Transplant	20% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	20% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Office Visit—Specialty Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Pediatric	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Outpatient Surgery	20% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	20% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	20% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	20% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

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ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Emergency Services (copayment waived if admitted)	$200 copayment per visit (deductible waived)	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment (deductible waived)	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit (deductible waived)	$50 copayment per visit (deductible waived)
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies
Temporomandibular Joint (TMJ) Disorder [1, 4]	20% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	20% coinsurance, after deductible	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	(deductible waived on all Tiers) **Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
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PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product (deductible waived)	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 1000d PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$1,000	$2,000
Per Family Unit	$3,000	$6,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
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Deductibles apply to all eligible services/benefits except for the following:

- Ambulance services;
- Emergency Services;
- Spinal Manipulations; and
- The following services received from Preferred Providers:
  - Office visits;
  - Urgent care,
  - Preventive care;
  - Well-child care;
  - Routine eye exams—Adult;
  - Routine eye exams—Pediatric;
  - Prescription Drugs; and
  - Specialty Prescription Drugs.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$4,500	$14,000
Per Family Unit	$12,000	$32,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	20% coinsurance, after deductible	50% coinsurance, after deductible

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ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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Human Organ Transplant	20% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	20% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Office Visit—Specialty Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Pediatric	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Outpatient Surgery	20% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	20% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	20% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	20% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	20% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

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ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Emergency Services (copayment waived if admitted)	$200 copayment per visit (deductible waived)	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment (deductible waived)	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies
Temporomandibular Joint (TMJ) Disorder [1, 4]	20% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	20% coinsurance, after deductible	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	(deductible waived on all Tiers) **Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 1000d PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	**You Pay Preferred Provider/Pharmacy**	**You Pay Non-Preferred Provider/Pharmacy**
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product (deductible waived)	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 2500 100% PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$2,500	$5,000
Per Family Unit	$7,500	$15,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 2500 100% PLAN OPTION

Deductibles apply to all eligible services/benefits except for the following:

- Ambulance services;
- Emergency Services;
- Urgent care;
- Spinal Manipulations; and
- The following services received from Preferred Providers:
  - Office visits;
  - Preventive care;
  - Well-child care;
  - Routine eye exams—Adult;
  - Routine eye exams—Pediatric;
  - Prescription Drugs; and
  - Specialty Prescription Drugs.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$2,500	$5,000
Per Family Unit	$7,5000	$15,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 2500 100% PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Rehabilitation and Skilled Nursing Facility [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Human Organ Transplant	0% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Office Visit—Specialty Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Pediatric	$40 copayment per exam (deductible waived)	50% coinsurance, after deductible
Outpatient Surgery	0% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	0% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	0% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	0% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

PPO 2500 100% PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Emergency Services (copayment waived if admitted)	$200 copayment per visit (deductible waived)	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment (deductible waived)	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies
Temporomandibular Joint (TMJ) Disorder [1, 4]	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	0% coinsurance, after deductible	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	(deductible waived on all Tiers) **Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
PPO 2500 100% PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	**You Pay Preferred Provider/Pharmacy**	**You Pay Non-Preferred Provider/Pharmacy**
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product (deductible waived)	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HDHP 3000 PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$3,000	$6,000
Per Family Unit	$6,000	$12,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HDHP 3000 PLAN OPTION

Deductibles apply to all eligible services/benefits except for the following Preferred Provider services/benefits:

- Wellness care; and
- Well-child care.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$3,000	$10,000
Per Family Unit	$6,000	$20,000

All deductibles and coinsurance apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Inpatient Rehabilitation and Skilled Nursing Facility [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Human Organ Transplant	0% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Office Visit—Specialty Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

HDHP 3000 PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	0% coinsurance, after deductible	50% coinsurance, after deductible
Routine Eye Exams—Pediatric	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Surgery	0% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	0% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	0% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	0% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	0% coinsurance, after deductible	50% coinsurance, after deductible
Durable Medical Equipment and Prosthetic Devices	0% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Emergency Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Ambulance Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Urgent Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Temporomandibular Joint (TMJ) Disorder [1, 4]	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HDHP 3000 PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	**Tier 1 (generic)**: 0% coinsurance per script, after deductible **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	**Tier 1 (generic)**: 0% coinsurance per script, after deductible **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	**Tier 4 (preferred)**: 0% coinsurance per script, after deductible **Tier 5 (non-preferred)**: 0% coinsurance per script, after deductible **Tier 6 (non-formulary)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	**Tier 1 (generic)**: 0% coinsurance per script **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	0% coinsurance per product **(deductible waived)**	Not covered

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Please Note:

- Under a Qualified High Deductible Health Plan (QHDHP) that is intended to be paired with a Health Savings Account, there is no first-dollar coverage permitted. This means that Covered Persons must meet the Calendar Year deductible(s) before any benefits are considered eligible by the Plan, with the exception of certain preventive care and well-child care services received by Preferred Providers.

- Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

- Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HDHP 5000 PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$5,000	$10,000
Per Family Unit	$10,000	$20,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HDHP 5000 PLAN OPTION

Deductibles apply to all eligible services/benefits except for the following Preferred Provider services/benefits:

- Wellness care; and
- Well-child care.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$5,000	$15,000
Per Family Unit	$10,000	$30,000

All deductibles and coinsurance apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Inpatient Rehabilitation and Skilled Nursing Facility [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Human Organ Transplant	0% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Office Visit—Specialty Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

HDHP 5000 PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	0% coinsurance, after deductible	50% coinsurance, after deductible
Routine Eye Exams—Pediatric	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Surgery	0% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	0% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	0% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	0% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	0% coinsurance, after deductible	50% coinsurance, after deductible
Durable Medical Equipment and Prosthetic Devices	0% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Emergency Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Ambulance Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Urgent Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Temporomandibular Joint (TMJ) Disorder [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

HDHP 5000 PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	**Tier 1 (generic)**: 0% coinsurance per script, after deductible **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	**Tier 1 (generic)**: 0% coinsurance per script, after deductible **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	**Tier 4 (preferred)**: 0% coinsurance per script, after deductible **Tier 5 (non-preferred)**: 0% coinsurance per script, after deductible **Tier 6 (non-formulary)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	**Tier 1 (generic)**: 0% coinsurance per script **Tier 2 (preferred brand)**: 0% coinsurance per script, after deductible **Tier 3 (non-preferred brand)**: 0% coinsurance per script, after deductible	50% coinsurance per script, after deductible
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	0% coinsurance per product **(deductible waived)**	Not covered

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Please Note:

- Under a Qualified High Deductible Health Plan (QHDHP) that is intended to be paired with a Health Savings Account, there is no first-dollar coverage permitted. This means that Covered Persons must meet the Calendar Year deductible(s) before any benefits are considered eligible by the Plan, with the exception of certain preventive care and well-child care services received by Preferred Providers.

- Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

- Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 100% PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$2,500	$5,000
Per Family Unit	$7,500	$15,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 100% PLAN OPTION

Deductibles apply to all eligible services/benefits except for the following:

- Ambulance services;
- Emergency Services;
- Urgent care;
- Spinal Manipulations; and
- The following services received from Preferred Providers:
  - Office visits;
  - Preventive care;
  - Well-child care;
  - Routine eye exams—Adult;
  - Routine eye exams—Pediatric;
  - Prescription Drugs; and
  - Specialty Prescription Drugs.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$2,500	$5,000
Per Family Unit	$7,500	$15,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Care	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 100% PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Rehabilitation and Skilled Nursing Facility [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Human Organ Transplant	0% coinsurance, after deductible	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	0% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Office Visit—Specialty Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance (deductible waived)	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam (deductible waived)	*Not considered an Eligible Expense*
Routine Eye Exams—Pediatric	$40 copayment per exam (deductible waived)	*Not considered an Eligible Expense*
Outpatient Surgery	0% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	0% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	0% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit (deductible waived)	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	0% coinsurance, after deductible	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	0% coinsurance, after deductible	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	0% coinsurance, after deductible	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	0% coinsurance, after deductible	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 100% PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Emergency Services (copayment waived if admitted)	$200 copayment per visit (deductible waived)	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment (deductible waived)	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit (deductible waived)	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies
Temporomandibular Joint (TMJ) Disorder [1, 4]	0% coinsurance, after deductible	50% coinsurance, after deductible
Other Services/Benefits	0% coinsurance, after deductible	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	(deductible waived on all Tiers) **Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 100% PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product (deductible waived)	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 1000d PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$0	$5,000
Per Family Unit	$0	$10,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 1000d PLAN OPTION

Non-Preferred Provider deductibles apply to all eligible Non-Preferred Provider services/benefits except for the following:

- Ambulance services;
- Emergency Services; and
- Spinal Manipulations.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$3,000	$10,000
Per Family Unit	$6,000	$20,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	20% coinsurance	50% coinsurance, after deductible
Hospital Care	$1,000 copayment per admission, then 20% coinsurance	50% coinsurance, after deductible
Inpatient Rehabilitation and Skilled Nursing Facility [1]	20% coinsurance	50% coinsurance, after deductible
Human Organ Transplant	20% coinsurance	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	$1,000 copayment per admission, then 20% coinsurance	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 1000d PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Office Visit—Specialty Care	$50 copayment per visit	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam	*Not considered an Eligible Expense*
Routine Eye Exams—Pediatric	$40 copayment per exam	*Not considered an Eligible Expense*
Outpatient Surgery	$1,000 copayment per procedure, then 20% coinsurance	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	$500 copayment per procedure, then 20% coinsurance	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	20% coinsurance	50% coinsurance, after deductible
Hospice Care	20% coinsurance	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	20% coinsurance	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	20% coinsurance	50% coinsurance, after deductible
Emergency Services (copayment waived if admitted)	$200 copayment per visit	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 1000d PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Temporomandibular Joint (TMJ) Disorder [1, 4]	20% coinsurance	50% coinsurance, after deductible
Other Services/Benefits	20% coinsurance	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	**Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	**Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	**Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	**Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 2000d PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Infertility Services—Oocyte Retrievals Only	Varies. See the section "MEDICAL BENEFITS—ELIGIBLE EXPENSES, Infertility Services" for detailed information.
Temporomandibular Joint (TMJ) Disorder [4]	$2,500 per Covered Person
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Autism Spectrum Disorders, per Covered Person under age 21	Up to the amount allowed by applicable law To find out the maximum amount eligible under this benefit, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.
Inpatient Rehabilitation and Skilled Nursing Facility	120 days per Covered Person
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 20 visits per Covered Person
Spinal Manipulations [4]	$500 per Covered Person

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$0	$5,000
Per Family Unit	$0	$10,000

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 2000d PLAN OPTION

Non-Preferred Provider deductibles apply to all eligible Non-Preferred Provider services/benefits except for the following:

- Ambulance services;
- Emergency Services; and
- Spinal Manipulations.

A new deductible will apply each Calendar Year. The Family Unit Calendar Year deductible is cumulative for all members of a Family Unit.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$4,000	$10,000
Per Family Unit	$8,000	$20,000

All deductibles, coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	20% coinsurance	50% coinsurance, after deductible
Hospital Care	$2,000 copayment per admission, then 20% coinsurance	50% coinsurance, after deductible
Inpatient Rehabilitation and Skilled Nursing Facility [1]	20% coinsurance	50% coinsurance, after deductible
Human Organ Transplant	20% coinsurance	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	$2,000 copayment per admission, then 20% coinsurance	50% coinsurance, after deductible
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit	50% coinsurance, after deductible

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

POS-C 2000d PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Office Visit—Specialty Care	$50 copayment per visit	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance	50% coinsurance, after deductible
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance	50% coinsurance, after deductible
Well-Child Care Services	0% coinsurance	50% coinsurance, after deductible
Routine Eye Exams—Adult	$40 copayment per exam	*Not considered an Eligible Expense*
Routine Eye Exams—Pediatric	$40 copayment per exam	*Not considered an Eligible Expense*
Outpatient Surgery	$2,000 copayment per procedure, then 20% coinsurance	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance	50% coinsurance, after deductible
Imaging (CT/PET scans, MRIs)	$1,000 copayment per procedure, then 20% coinsurance	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	20% coinsurance	50% coinsurance, after deductible
Hospice Care	20% coinsurance	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit	50% coinsurance, after deductible
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance	50% coinsurance, after deductible
Spinal Manipulations [1, 4]	50% coinsurance	50% coinsurance (deductible waived)
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	50% coinsurance, after deductible
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	20% coinsurance	50% coinsurance, after deductible
Cardiac Rehabilitation [1]	20% coinsurance	50% coinsurance, after deductible
Emergency Services (copayment waived if admitted)	$200 copayment per visit	$200 copayment per visit (deductible waived)
Ambulance Services	$100 copayment	$100 copayment (deductible waived)
Urgent Care	$50 copayment per visit	50% coinsurance, after deductible
Other Services/Benefits		
Infertility Services (enhanced services) [1]	Office Visit/Hospital Care copayment/coinsurance applies	Office Visit/Hospital Care copayment/coinsurance applies

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C 2000d PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Temporomandibular Joint (TMJ) Disorder [1, 4]	20% coinsurance	50% coinsurance, after deductible
Other Services/Benefits	20% coinsurance	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	**Tier 1 (generic)**: $7 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	**Tier 1 (generic)**: $19.25 copayment per script **Tier 2 (preferred brand)**: $96.25 copayment per script **Tier 3 (non-preferred brand)**: $192.50 copayment per script	50% coinsurance per script, after deductible
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	**Tier 4 (preferred)**: $140 copayment per script **Tier 5 (non-preferred)**: $210 copayment per script **Tier 6 (non-formulary)**: 50% coinsurance per script	50% coinsurance per script, after deductible
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	**Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $35 copayment per script **Tier 3 (non-preferred brand)**: $70 copayment per script	50% coinsurance per script, after deductible
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Non-Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HMO 80 PLAN OPTION

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Individual Lifetime Maximum Benefit	Unlimited
Smoking Cessation Program	Three programs per Covered Person

The term "Lifetime" refers to the time a person is actually a Covered Person of a welfare benefit plan sponsored by the Plan Administrator/Plan Sponsor and is not intended to suggest benefits beyond an individual's termination date.

CALENDAR YEAR MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Outpatient Rehabilitative Therapy Services (occupational, physical and speech therapies)	60 visits per Covered Person (treatment combined)
Cardiac Rehabilitation	36 sessions within six months of date of event, per Covered Person
Speech Therapy for Pervasive Developmental Disorders	Additional 60 visits per Covered Person
Routine Eye Exams—Adult	1 exam every 12 months

OTHER MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
Smoking Cessation Program	One program per 12-month period up to the Lifetime maximum benefit amount, per Covered Person

CALENDAR YEAR DEDUCTIBLES	Your deductible responsibility for Preferred Providers	Your deductible responsibility for Non-Preferred Providers
Per Individual	$0	Not Applicable
Per Family Unit	$0	Not Applicable

CALENDAR YEAR MAXIMUM OUT-OF-POCKET LIMITS	Your out-of-pocket responsibility for Preferred Providers	Your out-of-pocket responsibility for Non-Preferred Providers
Per Individual	$2,000	Not Applicable
Per Family Unit	$4,000	Not Applicable

All coinsurance and copayments apply to the Calendar Year maximum out-of-pocket limits. Expenses over the Maximum Allowable Charge and excluded services do not apply to the Calendar Year maximum out-of-pocket limits.

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HMO 80 PLAN OPTION

The Family Unit Calendar Year maximum out-of-pocket limits are cumulative for all members of a Family Unit.

PREAUTHORIZATION PENALTY	Your Preauthorization penalty responsibility for Preferred Providers and Non-Preferred Providers
Failure to Preauthorize	There is no Preauthorization penalty for failure to Preauthorize the Listed Services.

Preauthorization by the Utilization Review Manager is required for certain healthcare services. For more details about the Preauthorization requirements and Listed Services that require Preauthorization, please see the "PREAUTHORIZATION" section of this document.

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Inpatient Services/Benefits		
Physician Services	20% coinsurance	*Not considered an Eligible Expense*
Hospital Care	20% coinsurance	*Not considered an Eligible Expense*
Inpatient Rehabilitation and Skilled Nursing Facility [1]	20% coinsurance	*Not considered an Eligible Expense*
Human Organ Transplant	20% coinsurance	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment	20% coinsurance	*Not considered an Eligible Expense*
Outpatient Services/Benefits		
Office Visit—Primary Care	$25 copayment per visit	*Not considered an Eligible Expense*
Office Visit—Specialty Care	$50 copayment per visit	*Not considered an Eligible Expense*
Routine Prenatal Care	20% coinsurance	*Not considered an Eligible Expense*
Preventive Care Services ("Be Healthy" program; see "Exhibit 1" for a comprehensive list of preventive care services available under the Plan.)	0% coinsurance	*Not considered an Eligible Expense*
Well-Child Care Services	0% coinsurance	*Not considered an Eligible Expense*
Routine Eye Exams—Adult [1]	$40 copayment per exam	*Not considered an Eligible Expense*
Outpatient Surgery	20% coinsurance	*Not considered an Eligible Expense*
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance	*Not considered an Eligible Expense*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

HMO 80 PLAN OPTION

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Imaging (CT/PET scans, MRIs)	20% coinsurance	*Not considered an Eligible Expense*
Hospice Care	20% coinsurance	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment—Office Visit	$25 copayment per visit	*Not considered an Eligible Expense*
Mental Health/Substance Use Disorder Services and Treatment—All Outpatient Services (except office visit)	20% coinsurance	*Not considered an Eligible Expense*
Spinal Manipulations[3, 4]	$20 copayment per visit	*Not considered an Eligible Expense*
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	*Not considered an Eligible Expense*
Rehabilitative Therapy Services (occupational, physical and speech therapies) [1]	20% coinsurance	*Not considered an Eligible Expense*
Cardiac Rehabilitation [1]	20% coinsurance	*Not considered an Eligible Expense*
Emergency Services (copayment waived if admitted)	$200 copayment per visit	$200 copayment per visit
Ambulance Services	$100 copayment	$100 copayment
Urgent Care	$50 copayment per visit	$50 copayment per visit
Other Services/Benefits		
Other Services/Benefits	20% coinsurance	*Not considered an Eligible Expense*

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Retail Prescription Drugs (limited to a maximum 30-day supply)	**Tier 1 (generic)**: $20 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 copayment per script	*Not considered an Eligible Expense*
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	**Tier 1 (generic)**: $55 copayment per script **Tier 2 (preferred brand)**: $110 copayment per script **Tier 3 (non-preferred brand)**: $137.50 copayment per script	*Not considered an Eligible Expense*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HMO 80 PLAN OPTION

PRESCRIPTION DRUG BENEFITS ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Specialty Prescription Drugs (limited to a maximum 30-day supply; scripts must be obtained through an exclusive specialty Pharmacy)	**Tier 4 (preferred)**: 20% coinsurance per script **Tier 5 (non-preferred)**: 20% coinsurance per script **Tier 6 (non-formulary)**: 20% coinsurance per script	*Not considered an Eligible Expense*
Prescription Pharmacy Contraceptives [2] (e.g., oral Contraceptives, patches, ring; limited to one Contraceptive product per month)	**Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 copayment per script	*Not considered an Eligible Expense*
FDA-Approved, Over-the-Counter (OTC) Contraceptive Products for Women (limited to one Contraceptive product per month) [3]	$0 copayment per product	*Not considered an Eligible Expense*

[1] See the "LIFETIME MAXIMUM BENEFITS" or "CALENDAR YEAR MAXIMUM BENEFITS" subsections for benefit limitations.

[2] If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost sharing, and may be subject to reasonable medical management.

[3] FDA-approved, over-the-counter (OTC) Contraceptives for women, including, but not limited to, condoms, sponges and spermicide are considered Eligible Expenses. A prescription is required from a Physician.

[4] This benefit is not considered an Essential Health Benefit.

Preferred Provider coinsurance is based on the Maximum Allowable Charges. In addition to the coinsurance, the Covered Person also pays any expenses incurred in excess of the Maximum Allowable Charges.

Preferred Provider coinsurance, if any, is based on the allowed or discounted amount, not on the billed amount.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

Please refer to the "ADDENDUM A" section of this Plan for the eligibility, funding, effective date and termination provisions that apply to the benefits provided by your specific Employer.

MEDICAL BENEFITS

Verification of Benefits. Call the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document to verify Plan benefits before the expense is incurred.

Medical Benefit Expenses. Medical benefits apply when Eligible Expenses are incurred by a Covered Person for care and treatment of an Injury or Sickness and while the person is covered under the Plan.

All expenses that are eligible under the Plan are subject to the exclusions and limitations described more fully herein including, but not limited to:

(1) the determination that care and treatment is Medically Necessary and appropriate;

(2) the determination that care, treatment, services and supplies are not experimental and/or investigational; and

(3) Eligible Expenses are based on contract rates (when using Preferred Providers) and Maximum Allowable Charges (when using Non-Preferred Providers).

PLAN OPTIONS

This Plan contains the following Plan option(s) which is/are more fully described below:

- Preferred Provider Organization (PPO) Plan option
- Qualified High Deductible Health Plan (QHDHP) option
- Point-of-Service (POS) Plan option
- HMO Plan option

If assistance is needed in determining which Plan option(s) applies to you, please contact the Plan Administrator/Plan Sponsor at the telephone number listed in the "GENERAL PLAN INFORMATION" section of this document.

Preferred Provider Organization (PPO) Plan Option. This Plan has entered into an agreement with certain Hospitals, Physicians and other healthcare Providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person uses Preferred Providers, that Covered Person will receive a higher payment from the Plan than when Non-Preferred Providers are used. It is the Covered Person's choice as to which Provider to use. See the "SCHEDULE OF BENEFITS" section for a description of Preferred Provider benefits and Non-Preferred Provider benefits.

Contact Information for Preferred Providers:

Network Name:	Health Alliance Network with Christie Clinic Providers Effective 7/1/2018: Sarah Bush Lincoln Health Center is considered a Preferred Provider through a direct contract with the Illinois Educators Risk Management Program Association	
Network Address:	Through February 28, 2018: 301 S. Vine St., Urbana, IL 61801	As of March 1, 2018: 3310 Fields South Drive, Champaign, IL 61822
Network Telephone:	1-800-322-7451	
Network Website:	HealthAlliance.org	

A Covered Person is not required to select a Primary Care Physician or obtain a referral for healthcare services that are Medically Necessary for the treatment, maintenance or improvement of health. However, Preauthorization by the Utilization Review Manager is required for Listed Services (see the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section of this document).

This Plan allows a Covered Person to choose their healthcare services Provider. The Plan benefit level is determined by the type of Provider used. A Covered Person who receives services from Preferred Providers will generally receive the highest level of benefits under the Plan. A Covered Person who receives services from Non-Preferred Providers will generally receive the lowest level of benefits under the Plan, and possibly no benefits under the Plan. Expenses incurred for services provided by Preferred Providers are not subject to the Maximum Allowable Charge limitations because of their contracts with the Plan.

Services, supplies or treatments provided by a Non-Preferred Physician or at a Non-Preferred Provider facility, which are considered Eligible Expenses under the Plan, may be reimbursed at the applicable Preferred Provider benefit level, as shown in the "SCHEDULE OF BENEFITS" section, under the following circumstances:

(1) If a Covered Person requires services from a Non-Preferred Provider for a service or supply not available in the network service area, if such service or supply is Preauthorized by the Utilization Review Manager;

(2) If a Covered Person is outside of the network service area and has a Medical Emergency requiring immediate care;

(3) If a Covered Person received services or supplies from a Non-Preferred Physician (including, but not limited to, anesthesiologist, pathologist, radiologist, etc.) at a Preferred Provider facility, based on Utilization Review Manager and/or Plan Administrator/Plan Sponsor review.

Qualified High Deductible Health Plan (QHDHP) Option. A Qualified High Deductible Health Plan (QHDHP) that is designed to be paired with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. This Plan gives a Covered Person greater control over how healthcare benefits are used. A QHDHP satisfies certain statutory requirements with respect to minimum deductibles and maximum out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses are set forth by the U.S. Department of Treasury and will be indexed for inflation from time to time.

Administration of the Health Savings Account is handled through the Health Savings Account Administrator specified in the "GENERAL PLAN INFORMATION" section of this document.

Please Note: Under a Qualified High Deductible Health Plan (QHDHP), that is designed to be paired with a Health Savings Account, there is no first-dollar coverage permitted. This means that Covered Persons must meet the Calendar Year deductible(s) before any benefits are provided for incurred Eligible Expenses, with the exception of certain Preferred Provider preventive care and well-child care services.

This Plan has entered into an agreement with certain Hospitals, Physicians and other healthcare Providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person uses Preferred Providers, that Covered Person will receive a higher payment from the Plan than when Non-Preferred Providers are used. It is the Covered Person's choice as to which Provider to use. See the "SCHEDULE OF BENEFITS" section for a description of Preferred Provider benefits and Non-Preferred Provider benefits.

Contact Information for Preferred Providers:

Network Name:	Health Alliance Network with Christie Clinic Providers Effective 7/1/2018: Sarah Bush Lincoln Health Center is considered a Preferred Provider through a direct contract with the Illinois Educators Risk Management Program Association	
Network Address:	Through February 28, 2018: 301 S. Vine St., Urbana, IL 61801	As of March 1, 2018: 3310 Fields South Drive, Champaign, IL 61822
Network Telephone:	1-800-322-7451	
Network Website:	HealthAlliance.org	

A Covered Person is not required to select a Primary Care Physician or obtain a referral for healthcare services that are

Medically Necessary for the treatment, maintenance or improvement of health. However, Preauthorization by the Utilization Review Manager is required for Listed Services (see the "PREATHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section of this document).

This Plan allows a Covered Person to choose their healthcare services Provider. The Plan benefit level is determined by the type of Provider used. A Covered Person who receives services from Preferred Providers will generally receive the highest level of benefits under the Plan. A Covered Person who receives services from Non-Preferred Providers will generally receive the lowest level of benefits under the Plan, and possibly no benefits under the Plan. Expenses incurred for services provided by Preferred Providers are not subject to the Maximum Allowable Charge limitations because of their contracts with the Plan.

Services, supplies or treatments provided by a Non-Preferred Physician or at a Non-Preferred Provider facility, which are considered Eligible Expenses under the Plan, may be reimbursed at the applicable Preferred Provider benefit level, as shown in the "SCHEDULE OF BENEFITS" section, under the following circumstances:

(1) If a Covered Person requires services from a Non-Preferred Provider for a service or supply not available in the network service area, if such service or supply is Preauthorized by the Utilization Review Manager;

(2) If a Covered Person is outside of the network service area and has a Medical Emergency requiring immediate care;

(3) If a Covered Person received services or supplies from a Non-Preferred Physician (including, but not limited to, anesthesiologist, pathologist, radiologist, etc.) at a Preferred Provider facility, based on Utilization Review Manager and/or Plan Administrator/Plan Sponsor review.

Point of Service (POS) Plan Option. This Plan has entered into an agreement with certain Hospitals, Physicians and other healthcare Providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person uses Preferred Providers, that Covered Person will receive a higher payment from the Plan than when Non-Preferred Providers are used. It is the Covered Person's choice as to which Provider to use. See the "SCHEDULE OF BENEFITS" section for a description of Preferred Provider benefits and Non-Preferred Provider benefits.

Contact Information for Preferred Providers:

Network Name:	Health Alliance Network with Christie Clinic Providers Effective 7/1/2018: Sarah Bush Lincoln Health Center is considered a Preferred Provider through a direct contract with the Illinois Educators Risk Management Program Association	
Network Address:	Through February 28, 2018: 301 S. Vine St., Urbana, IL 61801	As of March 1, 2018: 3310 Fields South Drive, Champaign, IL 61822
Network Telephone:	1-800-322-7451	
Network Website:	HealthAlliance.org	

Under this POS Plan option, expenses for healthcare services are considered eligible under the Plan only if the Primary Care Physician or Preferred Provider considers the service to be Medically Necessary for the treatment, maintenance or improvement of health. Listed Services are subject to Preauthorization by the Utilization Review Manager. Services received from Non-Preferred Providers are considered Eligible Expenses only when the Primary Care Physician refers the Covered Person, except as stated in the "ELIGIBLE EXPENSES—Emergency Services" subsection.

This Plan allows a Covered Person to choose their healthcare services Provider. The Plan benefit level is determined by the type of Provider used. If a Covered Person who receives services from Preferred Providers will generally receive the highest level of benefits under the Plan. A Covered Person who receives services from Non-Preferred Providers will generally receive the lowest level of benefits under the Plan, and possibly no benefits under the Plan. Expenses incurred for services provided by Preferred Providers are not subject to the Maximum Allowable Charge limitations because of their contracts with the Plan.

Services, supplies or treatments provided by a Non-Preferred Physician or at a Non-Preferred Provider facility, which are considered Eligible Expenses under the Plan, may be reimbursed at the applicable Preferred Provider benefit level, as shown in the "SCHEDULE OF BENEFITS" section, under the following circumstances:

(1) If a Covered Person is outside of the network service area and has a Medical Emergency requiring immediate care;

(2) If a Covered Person received services or supplies from a Non-Preferred Physician (including, but not limited to, anesthesiologist, pathologist, radiologist, etc.) at a Preferred Provider facility, based on Utilization Review Manager and/or Plan Administrator/Plan Sponsor review.

***Selecting a Primary Care Physician*—**The point of service (POS) plan option generally requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. If a PCP is not selected, one will be assigned. For information on how to select a PCP and for a list of participating PCPs, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

For children, you or your child's legal representative may designate a Physician (allopathic or osteopathic) who specializes in pediatrics as his or her PCP. The Physician must be a participating Provider in the Provider network.

Covered Persons may select an OB/GYN Principal Healthcare Provider, in addition to their PCP, to provide care and services within the scope of his or her license without a referral from a PCP. The OB/GYN Principal Healthcare Provider must be a participating Provider in the Provider network. Covered Persons do not need to obtain Preauthorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Provider network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for Listed Services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

***Access to Specialty Care*—**If your PCP believes specialty care is Medically Necessary and appropriate, he or she will refer you to a participating Provider in the Provider network. Your PCP will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, your PCP may give you a standing referral. A standing referral will be effective for either the time period or number of visits specified by your PCP.

Upon enrollment in the Plan, a PCP must be selected. A Covered Person may change his or her PCP by calling the telephone number listed on their Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document. If a PCP is not selected, one will be assigned.

To see a Preferred specialty Provider, a referral from the Covered Person's Primary Care Physician may be necessary. If a Covered Person bypasses his or her PCP and self-refers to a Preferred Provider, the services will be considered Eligible Expenses at the Non-Preferred benefit level with the following exceptions:

(1) Women may self-refer to a Preferred obstetrician or gynecologist.

(2) Covered Persons may self-refer to a Preferred optometrist for routine eye examinations.

HMO Plan Option. IMPORTANT: This HMO Plan option does not provide benefits for services received outside of the HMO network service area, with the exception of Emergency Services. Covered Persons are responsible for all costs associated with services received outside of the HMO network service area. This Plan provides benefits for Medically Necessary and appropriate healthcare services subject to certain provisions and limitations. For example, to receive the highest benefit level, a Covered Person must have all care coordinated by a Primary Care Physician (PCP). If the PCP recommends that a Covered Person receive care from a specialist or other provider, the PCP will refer the Covered Person to the appropriate provider. Preauthorization from the Utilization Review Manager is required for certain types of services and supplies. (See the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.)

Contact Information for Preferred Providers:

Network Name:	Health Alliance Network with Christie Clinic Providers Effective 7/1/2018: Sarah Bush Lincoln Health Center is considered a Preferred Provider through a direct contract with the Illinois Educators Risk Management Program Association	
Network Address:	Through February 28, 2018: 301 S. Vine St., Urbana, IL 61801	As of March 1, 2018: 3310 Fields South Drive, Champaign, IL 61822
Network Telephone:	1-800-322-7451	
Network Website:	HealthAlliance.org	

***Selecting a Primary Care Physician*—**The HMO plan option generally requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. If a PCP is not selected, one will be assigned. For information on how to select a PCP and for a list of participating PCPs, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

For children, you or your child's legal representative may designate a Physician (allopathic or osteopathic) who specializes in pediatrics as his or her PCP. The Physician must be a participating Provider in the Provider network.

Covered Persons may select an OB/GYN Principal Healthcare Provider, in addition to their PCP, to provide care and services within the scope of his or her license without a referral from a PCP. The OB/GYN Principal Healthcare Provider must be a participating Provider in the Provider network. Covered Persons do not need to obtain Preauthorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Provider network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for Listed Services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the Third Party Administrator at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

***Access to Specialty Care*—**If your PCP believes specialty care is Medically Necessary and appropriate, he or she will refer you to a participating Provider in the Provider network. Your PCP will determine the number of visits needed for specialty care. If you have a medical condition that requires ongoing specialty care, your PCP may give you a standing referral. A standing referral will be effective for either the time period or number of visits specified by your PCP.

Upon enrollment in the Plan, a PCP must be selected. A Covered Person may change his or her PCP by calling the telephone number listed on their Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document. If a PCP is not selected, one will be assigned.

To see a Preferred specialty Provider, a referral from the Covered Person's PCP may be necessary. If a Covered Person bypasses his or her PCP and self-refers to a Preferred Provider, the services will be considered Eligible Expenses at the Non-Preferred benefit level with the following exceptions:

(1) Covered Persons may self-refer to a Preferred obstetrician or gynecologist.

(2) Covered Persons may self-refer to a Preferred optometrist for routine eye examinations.

COLLEGE EXTENDED NETWORK PROGRAM

The College Extended Network Program may be a solution for a college student who:

- is an eligible Dependent child;
- is enrolled in the Plan;
- attends a school outside the Plan's established participating Provider network(s) area(s);

- will be in attendance for 90-consecutive days or longer; **and**

- does not have access to a participating Provider where he or she resides for the purpose of attending college.

The Program is not available to eligible Dependent children who have adequate access to a participating Provider or to eligible Dependent children who permanently reside outside the Plan's established participating Provider network(s) areas(s).

For complete information about the Program rules, requirements and benefits, contact the Third Party Administrator's Customer Service Department at the telephone number on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document. Completion of a student verification form is required at certain intervals.

CONTINUITY OF CARE

Continued Care Benefits with Terminating Physicians. Subject to all other Plan provisions and limitations, if the treating Physician's contract (that makes the Physician a Preferred Provider) terminates, expenses incurred with that Physician may continue to be considered at the Preferred Provider benefit level during a transitional period if the Covered Person is in an ongoing course of treatment or if she is Pregnant. The following conditions must be met:

(1) The Physician's contract termination did not involve potential harm to a patient or disciplinary action by a state licensing board;

(2) The Physician remains in the area; and

(3) The Physician agrees to abide by the terms and conditions of the terminating contract.

The Covered Person must contact the Third Party Administrator's Customer Service Department at the telephone number listed on his or her Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document within 30 days of receiving the termination notice if continued care benefits with a terminating Physician are desired.

- **Ongoing Course of Treatment**—If a Covered Person is in an ongoing course of treatment, the continued treatment will be considered an Eligible Expense at the Preferred Provider benefit level with that Physician for a period of 90 days. The 90-day period starts on the date the Covered Person receives notice from the Third Party Administrator that the Physician's contract is terminating.

- **Maternity Care**—If a Covered Person is Pregnant and has entered week 13 of her Pregnancy by the date of the Physician's termination, continued care will be considered an Eligible Expense at the Preferred Provider benefit level with that Provider through post-partum care.

Continued Care Benefits for New Covered Persons. If the treating Physician is not a participating Provider for the Plan, a Covered Person may be eligible for benefits of continued treatment during a transitional period with that Physician if in an ongoing course of treatment or if Pregnant. The Physician must agree to accept reimbursement rates similar to other participating Providers for the Plan, and comply with the Third Party Administrator's quality assurance requirements, policies and procedures. A Covered Person must contact the Third Party Administrator's Customer Service Department at the telephone number listed on his or her Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document within 15 days of his or her effective date of coverage if continued care benefits with a non-participating Physician are desired.

- **Ongoing Course of Treatment**—If a Covered Person is in an ongoing course of treatment, continued treatment will be considered an Eligible Expense at the Preferred Provider benefit level with the treating Physician for a period of 90 days from his or her effective date of coverage.

- **Maternity Care**—If a female Covered Person is Pregnant and has entered week 13 of her Pregnancy on her effective date of coverage, continued care will be considered an Eligible Expense at the Preferred Provider benefit level with the treating Physician through post-partum care.

DEDUCTIBLE

Deductible Amount. The deductible amount is a specified dollar amount that a Covered Person must pay towards Eligible Expenses incurred before any benefits will be provided by the Plan during the Calendar Year. The deductible amounts are shown in the "SCHEDULE OF BENEFITS" section. A new deductible will apply each Calendar Year.

Deductible Three-Month Carryover. Eligible Expenses incurred in and applied toward the deductible during the last three calendar-months of the year will be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the dollar amount shown in the "SCHEDULE OF BENEFITS" section has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be provided by the Plan for the Eligible Expenses incurred by a Covered Person in excess of the deductible amount, if applicable. Payment will be made at the appropriate benefit level as shown in the "SCHEDULE OF BENEFITS" section. No benefits will be provided in excess of the Calendar Year maximum benefit amounts or any listed limits of the Plan.

MAXIMUM OUT-OF-POCKET LIMITS

The maximum out-of-pocket limits are shown in the "SCHEDULE OF BENEFITS" section. This is the maximum dollar amount a Covered Person will pay in accumulated copayments, coinsurance and/or deductibles, as applicable, for most Eligible Expenses incurred during a Calendar Year. When a Covered Person reaches the applicable out-of-pocket limit, the Plan will consider eligible 100 percent of the remainder of Eligible Expenses incurred for the rest of the Calendar Year, unless otherwise stated herein.

Family Unit. When a Family Unit reaches the applicable out-of-pocket limit, then the Plan will provide100 percent of the remainder of Eligible Expenses incurred for the rest of the Calendar Year unless otherwise stated herein.

MAXIMUM BENEFIT AMOUNTS

The Calendar Year maximum benefit amounts shown in the "SCHEDULE OF BENEFITS" section are the maximum amount of benefits that the Plan will provide for the specified services during the Calendar Year for Eligible Expenses incurred by a Covered Person.

STATUS CHANGE CARRYOVER (NO LOSS/NO GAIN)

If a person covered under this Plan changes status from Employee to Dependent, or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the status change, credit will be given for deductibles and all amounts applied to maximums.

ELIGIBLE EXPENSES

This subsection describes the services and supplies that are considered Eligible Expenses under the Plan. Eligible Expenses are subject to contract rates (when using Preferred Providers) and Maximum Allowable Charges (when using Non-Preferred Providers), benefit limits, exclusions and other provisions and limitations of this Plan. Specified Listed Services require Preauthorization (see the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section). An Eligible Expense is considered incurred on the date that the service or supply is performed or furnished. **Benefit limitations are shown in the "SCHEDULE OF BENEFITS" section.**

Additional Surgical Opinion

A consultation with a board-certified surgeon is considered an Eligible Expense when surgery is recommended. If a second opinion does not confirm the primary surgeon's opinion, a third opinion is also considered an Eligible Expense.

Ambulance Services

- **Air Transportation**—Emergency transportation by air ambulance for an Emergency Medical Condition is considered an Eligible Expense. Air ambulance services are not considered Eligible Expenses when the Covered Person could be safely transported by ground ambulance or by means other than by ambulance.

- **Ground Transportation**—Emergency transportation by ground ambulance for an Emergency Medical Condition is considered an Eligible Expense.

Amino-Based Elemental Formulas
Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome are considered Eligible Expenses when prescribed by a Physician. (See also "Durable Medical Equipment and Orthopedic Appliances" and "Home Infusion Services" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section).

Autism Spectrum Disorders
Benefits for the diagnosis and treatment of Autism Spectrum Disorders for a Covered Person under age 21 are considered Eligible Expenses up to the annual maximum benefit allowed by applicable law. To find out the maximum benefit available, contact the Third Party Administrator's Customer Service Department at the phone number on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

Treatment includes the following:

(1) Psychiatric care, meaning direct, consultative or diagnostic services;

(2) Psychological care, meaning direct or consultative services;

(3) Habilitative or rehabilitative care, meaning professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual; and

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

For purposes of this subsection, "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed healthcare professional with expertise in treating the effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Benefits for early intervention services must be delivered by a certified early intervention specialist.

Expenses incurred that include a primary diagnosis code of autism are excluded from the Outpatient rehabilitative therapy services Benefit Period maximum benefit amount specified in the "SCHEDULE OF BENEFITS" section.

Bariatric Surgery (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Bariatric surgery for severe obesity is considered an Eligible Expense for select procedures determined by the Third Party Administrator's Medical Directors Committee to have significant published experience on long-term results for the treatment of severe obesity for patients who have documentation of participation in a Physician-supervised integrated, non-surgical weight loss program of at least six months duration within the last three years and who meet Medical Necessity criteria. Subsequent related surgery to treat complications from an eligible surgery is considered an Eligible Expense. Subsequent surgery because of failure to achieve or maintain long-term weight loss may not be considered an Eligible Expense. Reconstructive surgery to remove excess skin is not considered an Eligible Expense. Benefits are limited to individuals age 18 and older at the time of surgery. (See also "Obesity" and "Bariatric Surgery (Applies only to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Blood
Blood, blood products and blood transfusions are considered Eligible Expenses when ordered by a Physician. Costs related to the administration and procurement of blood and blood components are also considered Eligible Expenses,

including the processing and storage of blood donated by the Covered Person for his or her own use. (See also "Blood Processing" in the "PLAN EXCLUSIONS" section.)

Breast Cancer Pain Therapy
Pain therapy related to the treatment of breast cancer is considered an Eligible Expense. For purposes of this subsection, "pain therapy" means therapy that is medically based and includes reasonably defined goals, including but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Cancer Chemotherapy, Chemotherapeutics and Biologicals
Chemotherapy (including high-dose chemotherapy with bone marrow or peripheral stem cell transplantation), chemotherapeutics and/or biologicals prescribed for the treatment of cancer are considered Eligible Expenses when the chemotherapy, chemotherapeutics and/or biologicals are provided in accordance with an established protocol. (See also "Experimental Treatments/Procedures/Drugs/Devices/Transplants" in the "PLAN EXCLUSIONS" section.)

Cardiac Rehabilitation
Cardiac Rehabilitation Phase I, provided on an inpatient basis for an acute cardiac episode or surgery, is considered an Eligible Expense. Cardiac Rehabilitation Phase II, which is initiated immediately following Phase I, is considered an Eligible Expense. Repeat Phase II rehabilitation is considered a provisional Eligible Expense. Cardiac Rehabilitation Phase III is not considered an Eligible Expense. Cardiac rehabilitation is subject to the benefit limitations specified in the "SCHEDULE OF BENEFITS—CALENDAR YEAR MAXIMUM BENEFITS" section.

Clinical Trials
Routine patient costs for items and services incurred by a qualified individual in connection with participation in an approved clinical trial are considered Eligible Expenses. Routine patient costs include all items and services consistent with the benefits provided in this Plan that are typically considered Eligible Expenses for a Covered Person who is not participating in a clinical trial.

The Plan shall not:

(1) deny the individual participation in the clinical trial if the referring healthcare professional is a participating Provider and has concluded that the individual's participation in such trial would be appropriate or the Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate;

(2) subject to the "Limitations on Benefits" subparagraph below, deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in a clinical trial;

(3) discriminate against the qualified individual on the basis of the individual's participation in such trial.

Routine patient costs do not include any of the following:

(1) Costs associated with managing the research that is associated with the approved clinical trial;

(2) Costs of non-healthcare services that the patient is required to receive as a result of participation in the approved clinical trial;

(3) Costs of any services, procedures or tests that are provided solely to satisfy data collection, record keeping and analysis needs that are not used in the direct clinical management of the patient participating in the approved clinical trial;

(4) Costs paid for, or not charged for, by the approved clinical trial Providers;

(5) Costs for transportation, lodging, food and other expenses for the patient, patient's family member or a companion of the patient that are associated with travel to and from a facility where an approved clinical trial is conducted;

(6) Costs for services, items or drugs that are eligible for reimbursement from a source other than a patient's contract or policy providing for third party payment or prepayment of health or medical expenses, including the sponsor of the approved clinical trial; and

(7) Costs of an investigational drug or device that has not been approved for market by the United States Food and Drug Administration.

For purposes of this "Clinical Trials" subsection, a "qualified individual" means a Covered Person who is eligible to participate in an approved clinical trial, according to the trial protocol, with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring healthcare professional is a participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate.

Additionally, an "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition (i.e., likely to lead to death unless the course of the disease or condition is interrupted), and is described in any of the following:

(1) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(a) The National Institutes of Health;

(b) The Centers for Disease Control and Prevention;

(c) The Agency for Health Care Research and Quality;

(d) The Centers for Medicare & Medicaid Services;

(e) Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;

(f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

(g) Any of the following:

- The Department of Veterans Affairs;
- The Department of Defense;
- The Department of Energy;

if the conditions for departments are met. The conditions for a study or investigation conducted by a Department are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines (1) to be comparable to the system of peer review of studies and investigation used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Use of Preferred Providers—If one or more participating Providers is participating in a clinical trial, nothing in the second paragraph of this "Clinical Trials" subsection shall be construed as preventing the Plan from requiring that a qualified individual participate in the trial through such a participating Provider if the Provider will accept the individual as a participant of the trial.

Use of Non-Preferred Providers—Notwithstanding the above paragraph "Use of Preferred Providers," the second paragraph of this "Clinical Trials" subsection shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

Limitations on Benefits—This "Clinical Trials" subsection shall not be construed to require the Plan to provide benefits for routine patient care services provided outside of the Plan's healthcare Provider network unless out-of-network benefits are otherwise provided under the Plan.

Note: Nothing in this "Clinical Trials" subsection shall be construed to limit the Plan's benefits with respect to clinical trials.

See also "Experimental Treatments/Procedures/Drugs/Devices/Transplants" in the "PLAN EXCLUSIONS" section.

Contraceptive Devices, Injectables, Procedures and Services
Federal Drug Administration (FDA)-approved prescription Contraceptive devices, injections, procedures and services are considered Eligible Expenses as follows:

(1) Devices and the medical fitting and insertion of devices for Contraceptive purposes only are considered Eligible Expenses under the preventive care services benefit. This includes, but is not limited to: IUDs, diaphragms, cervical caps or Contraceptive implants.

Services related to follow-up and management of side effects, counseling for continued adherence and device removal are also considered Eligible Expenses.

(2) Injectables and the injection intended for female Contraceptive purposes only are considered Eligible Expenses under the preventive care services benefit. This includes, but is not limited to DepoProvera®.

(3) Sterilization procedures intended for female Contraceptive purposes only are considered Eligible Expenses under the preventive care services benefit. (See also "Sterilization Procedures" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Prescription Contraceptives, including but not limited to, oral Contraceptives, patches or the ring are not considered Eligible Expenses under the "MEDICAL BENEFITS" section of this Plan (see the "PRESCRIPTION DRUG BENEFITS" section).

Additional expenses are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

Complications arising in connection with any Contraceptive method, other than follow-up and management of side effects, counseling for continued adherence and device removal are considered Eligible Expenses and will be payable pursuant to normal Plan benefit levels, provisions and limitations.

Dental Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Hospitalization for dental work is considered an Eligible Expense for covered Dependent children age six and under, Covered Persons with a medical condition that requires hospitalization or general anesthesia for dental care or for Covered Persons who are disabled. (See also "Oral Surgery" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section for other services that are considered Eligible Expenses under the Plan.)

See also "Dental Services" under the "PLAN EXCLUSIONS" section.

Diabetic Equipment and Supplies
Blood glucose monitors, blood glucose monitors for the legally blind, and cartridges for the legally blind, lancets and lancing devices are considered Eligible Expenses when ordered by a Physician and are subject to the Durable Medical Equipment coinsurance amount shown in the "SCHEDULE OF BENEFITS" section.

Diabetic Self-Management Training and Education
Outpatient self-management training and education, including nutritional training, for the treatment of types 1 and 2 diabetes and gestational diabetes mellitus are considered Eligible Expenses.

Diagnostic Testing
X-ray examinations, laboratory tests and pathology services are considered Eligible Expenses when ordered by a Physician.

Dressings and Supplies
Dressings, splints, casts and related supplies are considered Eligible Expenses and when administered by a Physician or by a nurse or other healthcare professional under the direction of a Physician.

Durable Medical Equipment and Orthopedic Appliances
Corrective and orthopedic appliances (such as leg braces and knee sleeves) and Durable Medical Equipment for home use (such as wheelchairs, surgical beds and oxygen equipment) are considered Eligible Expenses due to an Injury, Illness or medical condition. Items and supplies must be prescribed by a Physician. The Third Party Administrator, on behalf of the Plan, determines whether the equipment is made available through rental or purchase agreements. Costs associated with the repair of eligible equipment are considered Eligible Expenses if the Third Party Administrator determines the equipment has been properly maintained. Ostomy supplies are considered Eligible Expenses but other disposable supplies are not considered Eligible Expenses. (See also "Disposable Items" and "Durable Medical Equipment, Orthopedic Appliances and Devices" in the "PLAN EXCLUSIONS" section.)

To be consistent with changes in medical technology, the Third Party Administrator maintains a list of eligible and excluded items and the maximum amount payable under this benefit. Benefits can be verified by calling the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

Emergency Services
Emergency Services received for an Emergency Medical Condition are considered Eligible Expenses. In an emergency, seek immediate care or call 911 if it is available in your area. If Emergency Services are subject to a copayment, the copayment is waived if the Covered Person is admitted to the Hospital.

If admitted to a Non-Preferred Provider Hospital, the Covered Person, or someone acting on his or her behalf, the Hospital or the attending Physician must notify the Third Party Administrator's Customer Service Department at the telephone number listed on the Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document within 48 hours, or as soon as reasonably possible, after care begins.

In a Medical Emergency, a Covered Person may use Non-Preferred Providers and have benefits considered eligible by the Plan at the Preferred Provider benefit level.

See also "Foreign Travel" in the "PLAN EXCLUSIONS" section.

Erectile Dysfunction (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Treatment for male Covered Persons with documented erectile dysfunction without a correctable cause is considered an Eligible Expense. Prescription medications are considered Eligible Expenses under the ""PRESCRIPTION DRUG BENEFITS" section of the Plan. (See also "Erectile Dysfunction (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Genetic Testing (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Genetic testing for high-risk patients for certain diagnoses (including, but not limited to: breast cancer, cystic fibrosis, hemoglobin disorders) is considered an Eligible Expense when medical criteria has been met. Genetic testing is not considered an Eligible Expense for individuals from the general population with average risk. (See also "Genetic Testing (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Habilitative Services
Habilitative Services are considered Eligible Expenses if all of the following conditions are met:

(1) The Covered Person has been diagnosed with a congenital, genetic or early-acquired disorder by a Physician;

(2) Treatment must be Medically Necessary and therapeutic; and

(3) Treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, optometrist, licensed nutritionist, or psychologist upon the referral of a Physician.

Treatments that are experimental or investigational are not considered Eligible Expenses. Services that are solely educational in nature or reimbursed under state or federal law are not considered Eligible Expenses. Treatment of serious and non-serious Mental Disorders or other mandated benefits are not included under this benefit.

Hearing Evaluations (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Hearing evaluations are considered Eligible Expenses when provided by a licensed audiologist. Hearing aids, their fittings or testing for the purpose of using a hearing aid are not considered Eligible Expenses. (See also "Hearing Aids" and "Hearing Evaluations (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Home Health Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Intermittent skilled nursing and skilled therapeutic home services for homebound Covered Persons are considered Eligible Expenses when the services are given under the direction of a Physician. Non-skilled care provided by home health aides is not considered an Eligible Expense. (See also "Home Health Services (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Home Infusion Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Home infusion services, including medication and supplies, are considered Eligible Expenses when given under the direction of a Physician. (See also "Home Infusion Services (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

Hospice Care
Hospice Care Program expenses are considered Eligible Expenses when ordered by a Physician. A Hospice Care Program must meet the following requirements:

(1) It must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws.

(2) It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their Illness and, as estimated by a Physician, are expected to live less than 12 months as a result of that Illness.

(3) It must be administered by a Hospital, home health agency or other licensed facility.

Hospital Care
Hospital services are considered Eligible Expenses when hospitalization is ordered by a Physician. Benefits are limited to a semi-private (two-bed) accommodation, unless a medical condition warrants otherwise. A private room is considered an Eligible Expense if it is the only room available.

Benefits are provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient and for a post-discharge Physician office visit or in-home nurse visit within 48 hours after discharge.

Human Organ Transplant
Human organ transplants for non-experimental organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, are considered Eligible Expenses upon prior order and written referral of a Physician and upon the findings of a Medical Director that the recommended treatment is Medically Necessary and appropriate and is not excluded from coverage under any other sections of this Plan Document/Summary Plan Description. Transplants

must be performed at a facility approved by the Plan Administrator/Plan Sponsor or its designee. Benefits begin with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and through one year after transplant. Office visit and Hospital Care copayments or coinsurance apply as shown in the "SCHEDULE OF BENEFITS" section.

Organ and tissue procurement is considered an Eligible Expense. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.

The following human organ donor expenses are considered Eligible Expenses:

- If both the donor and the recipient are Covered Persons under the Plan, each shall have their benefits computed in accordance with the provisions of their own coverage.

- If the Covered Person under the Plan is the recipient and the donor has no other source of benefits, donor expenses will be applied to the Covered Person's benefits.

- If the Covered Person under the Plan is the donor and no benefits are available to the Covered Person from any other source, benefits for donor expenses will be provided to the Covered Person under the Plan. No benefits shall be provided to the recipient.

Transportation, lodging and meals for the transplant recipient and a companion for travel to and from the designated transplant center are considered Eligible Expenses. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Mileage for each Medically Necessary trip to and from the transplant facility shall be reimbursed at the standard mileage rate issued by the Internal Revenue Service for the year in which the expense is incurred for medical travel. Eligible Expenses for meals and lodging required during medical travel more than 50 miles (round trip) from the transplant recipient's home shall be reimbursed based on per diem allowances issued by the Internal Revenue Service for the period during which the expense is incurred.

If a Covered Person has primary coverage under Medicare Parts A and B, the Plan does not provide benefits for organ or tissue transplants that are not payable by Medicare.

See also "Human Organ Donor" in the "PLAN EXCLUSIONS" section.

Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Infertility services, including diagnosis and treatment, are considered Eligible Expenses when related to the diagnosis of Infertility. Benefits are subject to the following terms, conditions and limitations.

The following Infertility services are considered Eligible Expenses:

- Infertility evaluation by a Provider or mid-level Provider.

- Office visits related to the initial evaluation or follow-up appointments.

- Laboratory and X-ray, Huhner test (post coital test), hysterosalpingogram, laparoscopy, hysteroscopy, ultrasounds, sperm antibody test, artificial insemination, semen analysis, acrosome reaction test, urological evaluation, testicular biopsy.

- In-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and low tubal ovum transfer.

- Assisted reproductive technologies (ART), meaning the treatments and/or procedures in which the human oocytes and/or sperm are retrieved and the human oocytes and/or embryos are manipulated in the laboratory. ART includes Prescription Drug therapy used during the cycle where an oocyte retrieval is performed.

- Outpatient Prescription Drugs and Specialty Prescription Drugs for the treatment of Infertility (see also the "PRESCRIPTION DRUG BENEFITS" section).

- Infertility services after reversal of sterilization are considered Eligible Expenses if there is a successful reversal of sterilization and if the Covered Person's diagnosis meets the definition of "Infertility" as specified in the "DEFINED TERMS" section.

Benefit Limitation/Oocyte Retrieval Limitation—

- For Infertility services that include oocyte retrievals, benefits for such services are considered Eligible Expenses only if the Covered Person has been unable to attain or sustain a successful Pregnancy through reasonable, less costly medically appropriate Infertility services. This requirement shall be waived in the event that the Covered Person or partner has a medical condition that renders such treatment useless.

- For Infertility services that include oocyte retrievals, benefits for such services are limited to four completed oocyte retrievals per Lifetime of the Covered Person, except that two completed oocyte retrievals are considered Eligible Expenses after a live birth is achieved as a result of an artificial reproductive transfer of oocytes.

  For example, if a live birth takes place as a result of the first completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of three are considered Eligible Expenses. If a live birth takes place as a result of the fourth completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of six are considered Eligible Expenses.

  The maximum number of completed oocyte retrievals that are considered Eligible Expenses is six per Lifetime of the Covered Person.

NOTE: Once the final eligible oocyte retrieval is completed, one subsequent Infertility procedure used to transfer the oocytes or sperm is considered an Eligible Expense. After that, the benefit is exhausted and no further Infertility benefits are available.

NOTE: If the Covered Person had a completed oocyte retrieval in the past that was considered an eligible expense by another carrier, policy or plan (insured or uninsured), or was not covered by insurance, it still counts toward the Covered Person's Lifetime maximum benefit.

Donor Expenses. The medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the covered recipient, are considered Eligible Expenses.

The Plan has established prerequisites for donation. The following prerequisite donor services are considered Eligible Expenses and include, but are not limited to, physical examination, laboratory screening, psychological screening, and Prescription Drugs (see the "PRESCRIPTION DRUG BENEFITS" section).

Benefits for a known donor are considered Eligible Expenses. In the event the Covered Person does not have arrangements with a known donor, the use of a contracted facility is required. If the Covered Person uses a known donor, use of contracted Providers by the donor for all medical treatment, including but not limited to testing, Prescription Drug therapy and ART procedures, is required.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor will count against the Covered Person as one completed oocyte retrieval.

See also the "Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" and the "Infertility Services (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" subsections under the "PLAN EXCLUSIONS" section for a list of Infertility services that are considered excluded expenses under the Plan.

Injections
Injections that are inappropriate for self-administration are considered Eligible Expenses when administered by a Physician or a nurse under the direction of a Physician. Immunizations are considered Eligible Expenses under the preventive care services benefit.

Mandibular and Maxillary Osteotomy (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
A mandibular or maxillary osteotomy is considered an Eligible Expense only for significant functional problems that have not been corrected with dental and/or orthodontic treatment. (See also "Mandibular and Maxillary Osteotomy (Applies to Covered Persons enrolled in the HMO Plan Option)" in the "PLAN EXCLUSIONS" section.)

See also "Temporomandibular Joint (TMJ) Disorder" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.

Maternity Care
Prenatal care, delivery and postnatal care are considered Eligible Expenses.

A minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by Caesarean section are considered Eligible Expenses. A Physician may determine after consultation with the mother that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of a Physician, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge is also considered an Eligible Expense.

Gestational diabetes screening for women 24 to 28 weeks Pregnant and those at high risk of developing gestational diabetes is considered an Eligible Expense under the preventive care services benefit.

Lactation counseling and/or support and the rental or purchase of a breast pump is considered an Eligible Expense under the preventive care services benefit during Pregnancy and through the postpartum period.

Medical Social Services
Medical social services, including Hospital discharge planning and assistance in accessing community service agencies and other related services, are considered Eligible Expenses when needed to cope with a medical condition.

Medical Specialty Prescription Drugs
Medical Specialty Prescription Drugs are considered Eligible Expenses, subject to a prior written order by the Covered Person's Physician. Medical Specialty Drugs are Specialty Prescription Drugs that are received in the Physician's office and/or administered by a healthcare professional in an office or other healthcare setting.

To be consistent with changes in medical technology, the Third Party Administrator maintains a list of eligible medical Specialty Prescription Drugs and the medical conditions for which they are considered eligible under this benefit. Benefits that are eligible under the Plan can be verified by calling the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

See the "PRESCRIPTION DRUG BENEFITS" section for information on Pharmacy Prescription Drugs that are Eligible Expenses under the Plan.

Mental Health/Substance Use Disorder Services and Treatment
Expenses incurred for the following mental health/Substance Use Disorder services and treatments are considered Eligible Expenses:

- Inpatient and Outpatient treatment;
- Crisis intervention; and
- Rehabilitation services and treatment.

See also "Substance Use Detoxification" in this MEDICAL BENEFITS—ELIGIBLE EXPENSES" section and "Self-Inflicted Injury or Illness" in the "PLAN EXCLUSIONS" section.

Oral Surgery
Oral surgical procedures received in connection with the following limited conditions are considered Eligible Expenses:

(1) Traumatic Injury to sound natural teeth for non-restorative services within 30 days of Injury;

(2) Traumatic Injury to the jawbones or surrounding tissue within 30 days of Injury;

(3) Surgical removal of complete bony-impacted teeth;

(4) Correction of a non-dental pathological condition such as cysts and tumors;

(5) Medical dental work needed in order to treat cancer itself;

(6) Medical dental care required to be performed in order to treat another underlying medical condition such as malnutrition or digestive disorders.

Orthotics
Specially molded and custom-made orthotics are considered Eligible Expenses when prescribed by a Physician. The Durable Medical Equipment and orthopedic appliance coinsurance amount shown in the "SCHEDULE OF BENEFITS" section applies. Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure are considered Eligible Expenses.

See also "Durable Medical Equipment, Orthopedic Appliances and Devices" in the "PLAN EXCLUSIONS" section.

Pediatric Acute Onset Neuropsychiatric Syndrome
Treatment and services for pediatric acute onset neuropsychiatric syndrome, including but not limited to, the use of intravenous immunoglobulin therapy, are considered Eligible Expenses. Each service is subject to the deductible, copayments and coinsurance amounts as specified in the "SCHEDULE OF BENEFITS" section.

Pediatric Autoimmune Neuropsychiatric Disorders
Treatment and services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, including but not limited to, the use of intravenous immunoglobulin therapy, are considered Eligible Expenses. Each service is subject to the deductible, copayments and coinsurance amounts as specified in the "SCHEDULE OF BENEFITS" section.

Physician Services
Diagnostic and treatment services and preventive medical services provided by a Physician or under the supervision of a Physician, including recommended periodic healthcare examinations, are considered Eligible Expenses.

Expenses incurred for telehealth services are also considered Eligible Expenses. For purposes of this subsection, "telehealth services" means the delivery of eligible healthcare services between the patient and healthcare Provider over the telephone, via the Internet or by way of an interactive telecommunications system (e.g., an audio and video system permitting two-way, live interactive communication).

Podiatry Services
Podiatry services, including, but not limited to, services related to diabetes, are considered Eligible Expenses. (See also "Foot Care" in the "PLAN EXCLUSIONS" section.)

Preventive Care Services
Preventive care includes health services such as screenings, check-ups and patient counseling that are used to prevent Illnesses, disease, and other health problems, or to detect Illness at an early stage when treatment is likely to work best.

Annual physicals (limited to one physical per Calendar Year for eligible Dependent children) are considered Eligible Expenses.

Additional Eligible Expenses under this preventive care services benefit include, but are not limited to, the following: (For a complete listing of services available under this preventive care services benefit, refer to the "EXHIBIT 1—BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS" section.)

- **Alcohol and Drug Misuse Counseling and Screening**—Counseling and screening for alcohol and drug misuse.

- **Blood Pressure Screenings**—Blood pressure screenings for Covered Persons age 18 and older.

- **Bone Mass Measurement**—Bone mass measurement and diagnosis and treatment of osteoporosis.

- **BRCA Counseling and Evaluation**—BRCA counseling and evaluation for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes.

- **Breast Cancer Chemoprevention Counseling**—Breast cancer chemoprevention counseling for women at high risk for breast cancer and at low risk for adverse effects of chemoprevention.

- **Cholesterol/Lipid Screening**—Cholesterol or lipid screenings once every five years for Covered Persons age 20 and older.

  Additional cholesterol screenings or expenses are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Clinical Breast Exam**—A complete and thorough clinical breast exam to check for lumps and other changes for the purpose of early detection and prevention of breast cancer at least every three years for women at least 20 years of age but less than age 40, and annually for women age 40 or older.

- **Colorectal Cancer Screening**—A screening for colorectal cancer by means of colonoscopy every ten years (preferred) or sigmoidoscopy (every three years), and yearly fecal occult blood tests for average-risk Covered Persons age 50 and older; beginning at age 30 if a Covered Person or a first-degree family member has a history of colorectal cancer. Medically-appropriate medications, such as bowel preparation medications, prescribed by a Physician to prepare for a colonoscopy are also considered Eligible Expenses.

  Outpatient surgery copayments or coinsurance apply when procedures are performed in an Outpatient setting for which there is an associated facility fee.

  Additional colonoscopies or sigmoidoscopies or screenings performed prior to age 50 are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Depression Screening**—Depression screening for Covered Persons as part of a clinical exam to ensure accurate diagnosis and treatment follow-up.

- **Diabetes Screenings**—Diabetes screenings for Covered Persons with high blood pressure.

- **Diet and Nutritional Counseling**—Diet and nutritional counseling for Covered Persons at risk for chronic disease.

- **Domestic Violence Counseling and Screening**—Annual screening and counseling for interpersonal and domestic violence for women.

  Additional expenses or visits are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **High-Risk HPV Testing**—DNA testing in women age 30 and older, once every three years.

  Additional expenses or testing are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Injections and Immunizations**—Injections and immunizations, including, but not limited to:

  - human papillomavirus vaccine, and

  - shingles vaccine for Covered Persons age 60 or older.

For a complete listing of immunizations and immunization schedules, visit the Centers for Disease Control website at www.cdc.gov or the Third Party Administrator's website listed in the "GENERAL PLAN INFORMATION" section of this document.

Drugs that can be safely administered without the supervision of healthcare professionals will be administered at the most appropriate level of care. Unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups are not Eligible Expenses, unless otherwise specifically provided herein.

- **Mammograms**—Screening for the presence of occult breast cancer for women age 35 and older through the use of low-dose mammography as follows:

    - One baseline mammogram for women age 35 to 39.
    - One mammogram each year for women age 40 and older.
    - A mammogram at the age and intervals considered Medically Necessary by the individual's healthcare Provider for individuals under age 40 having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors.
    - A comprehensive ultrasound screening and MRI of an entire breast or breasts is considered an Eligible Expense if a mammogram demonstrates heterogeneous or dense breast tissue as determined by a Physician.
    - A screening MRI as determined by a Physician.

  A three-dimensional (3D) screening mammogram (breast tomosynthesis) is considered an Eligible Expense. A 3D diagnostic mammogram is considered an Eligible Expense under the diagnostic testing benefit.

  For purposes of this subsection, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this subsection, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

  Unless otherwise noted, all other screenings are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Obesity Counseling and Screenings**—An annual obesity screening and counseling as part of a clinical exam for adult Covered Persons and covered Dependent children age six and older. In addition to such screening, the United States Preventive Services Task Force (USPSTF) recommends, for adult Covered Persons with a body mass index (BMI) of 30 kg/m2 or higher, intensive, multi-component behavioral interventions for weight management. USPSTF's recommendation specifies that intensive, multi-component behavioral interventions include, for example, the following:

    - Group and individual sessions of high intensity (12 to 26 sessions in a year);
    - Behavioral management activities, such as weight-loss goals;
    - Improving diet or nutrition and increasing physical activity;
    - Addressing barriers to change;
    - Self-monitoring; and
    - Strategizing how to maintain lifestyle changes.

Additional expenses or screenings are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Pap Smear**—One cervical smear or Pap smear test each year for women.

  Additional Pap smear tests are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Prostate-Specific Antigen Tests**—Annual digital rectal exams and prostate-specific antigen tests for

  - Asymptomatic men age 50 and older,

  - African-American men age 40 and older, and

  - Men with a family history of prostate cancer age 40 and older, when authorized by a Physician.

  Additional prostate tests are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Sexually Transmitted Infection Counseling and Screening**—Annual counseling and screenings for sexually transmitted infections including, but not limited to, the human immune-deficiency virus (HIV) syphilis, gonorrhea, Chlamydia and human papillomavirus (HPV).

  Additional expenses or visits are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **Surveillance Test for Ovarian Cancer**—An annual screening for ovarian cancer using CA-125 serum tumor marking testing, transvaginal ultrasound or pelvic examination for females who are at risk of ovarian cancer.

- **Tobacco Use Screening**—A screening as part of a clinical exam to screen for tobacco use and to provide intervention methods. (See also "Smoking Cessation Program" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

- **Ultrasound for Abdominal Aortic Aneurysm**—A onetime ultrasound screening for men ages 65–75 who have ever smoked.

  Additional expenses or ultrasounds are subject to the deductibles, coinsurance and/or copayments listed in the "SCHEDULE OF BENEFITS" section.

- **United States Preventive Services Task Force (USPSTF)**—In addition to the preventive care services listed in this subsection, other routine preventive evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (for a list of current recommendations, visit the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/).

- **Well-Woman Preventive Care Visit**—An annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care.

  If a Physician or clinician determines that the patient requires additional well-woman visits in order to obtain all necessary recommended preventive services because of the woman's health status, health needs or other risk factors, then additional visits will be provided to the patient without cost sharing and may be subject to reasonable medical management.

- The following preventive care services for Pregnant women are considered Eligible Expenses, in addition to any preventive care service already listed:

  - Anemia screenings

- Breast feeding counseling and pumps (see also "Maternity Care" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section)
- Gestational diabetes screening (see also "Maternity Care" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section)
- Hepatitis B screening
- Rh Incompatibility screening, which also includes follow-up testing for women at high risk
- Urinary tract or other infection screenings

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service, then the Plan may use reasonable medical management techniques to determine any such benefit limitations.

In the event that the Plan does not have in its Preferred Provider network a Provider who can provide a particular eligible preventive care service, the Plan will consider a service performed by a Non-Preferred Provider as an Eligible Expense without imposing any cost sharing requirement on the Covered Person for the particular service/benefit. In this situation, the Plan will consider that particular preventive care service eligible at the Preferred Provider benefit level specified in the "SCHEDULE OF BENEFITS" section.

The Third Party Administrator maintains a list of eligible and excluded items and services and the maximum amount eligible under this benefit. Benefits that are eligible under the Plan can be verified by calling the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

Prosthetic Devices
Prosthetic devices are considered Eligible Expenses when due to an Illness or Injury. Prosthetic devices are fabricated substitutes for a diseased or missing part of the body such as a limb or an eye. Prosthetic devices must be prescribed by a Physician. The Durable Medical Equipment and orthopedic appliance coinsurance amount shown in the "SCHEDULE OF BENEFITS" section applies.

To be consistent with changes in medical technology, the Third Party Administrator maintains a list of eligible and excluded items and the maximum amount eligible under this benefit. Benefits that are eligible under this subsection can be verified by calling the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

See also "Durable Medical Equipment, Orthopedic Appliances and Devices" in the "PLAN EXCLUSIONS" section.

Reconstructive Surgery
Services to correct a functional defect resulting from an acquired and/or congenital disease or Injury are considered Eligible Expenses. Services performed to correct a seriously disfiguring condition resulting from accidental Injury or incident due to surgery are also considered Eligible Expenses; however, benefits are provided only if such condition has a major effect on appearance and the condition can be reasonably corrected by the surgery. Correction of a congenital defect or birth abnormality of an enrolled newborn is considered an Eligible Expense.

Expenses incurred for reconstructive surgery or for a prosthetic device following a mastectomy are considered Eligible Expenses. Benefits for breast reconstruction include the following:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) Reconstructive surgery of the other breast to produce a symmetrical and balanced appearance;

(3) Prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas; and

(4) Nipple and areola reconstruction, including nipple and areola repigmentation to restore the physical appearance of the breast.

See also “Cosmetic Surgery” in the “PLAN EXCLUSIONS” section.

Rehabilitation and Skilled Nursing Care—Inpatient
Inpatient Hospital services for rehabilitation and skilled nursing care in a Skilled Nursing Facility with ongoing documentation of Medical Necessity are considered Eligible Expenses. Services include, but are not limited to, inpatient speech, occupational and physical therapies. Benefits are limited as specified in the “SCHEDULE OF BENEFITS” section. (See also “Speech Therapy” in the “PLAN EXCLUSIONS” section.)

Rehabilitative Therapy Services—Outpatient
Rehabilitative therapies provided in an Outpatient or home setting (when the patient is homebound) that are directed at improving physical functioning and are expected to result in significant improvement within two months of commencement are considered Eligible Expenses. Speech therapy is considered an Eligible Expense if the speech loss or impairment is a result of trauma, stroke or surgery to the voice box or due to a congenital abnormality and significant improvement is expected within two months of commencement. Such therapies include, but are not limited to: speech, physical, occupational, cardiac (excluding Phase III) and pulmonary therapy services. Benefits are limited as specified in the “SCHEDULE OF BENEFITS” section. (See also “Speech Therapy” in the “PLAN EXCLUSIONS” section.)

Preventive physical therapy for the treatment of multiple sclerosis is considered an Eligible Expense when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

Self-Inflicted Injury or Sickness
Any loss due to an intentionally self-inflicted Injury or Sickness is considered an Eligible Expense.

Sexual Assault or Abuse Victims
Hospital and medical services in connection with sexual abuse or assaults that are of an emergency nature are considered Eligible Expenses. The deductible, copayment and/or coinsurance will be waived (this does not apply to a Covered Person who is enrolled in the QHDHP option).

Sleep Disorders
Sleep studies/tests, labs and medical equipment for sleep disorders are considered Eligible Expenses when ordered by a Physician. Preauthorization is required for sleep studies/tests done in a home setting. Medications prescribed for sleep aid are not considered Eligible Expenses under this Plan.

Smoking Cessation Program
One smoking cessation program per 12-month period up to a total of three smoking cessation programs per Lifetime is considered an Eligible Expense when provided through the Third Party Administrator’s “Quit for Life” smoking cessation program. Individuals enrolled in the “Quit for Life” smoking cessation program are eligible for a total of 90 days of benefits for any combination of the following: Bupropion®, Chantix® and over-the-counter Nicotine Replacement Therapy (NRT). NRT must be obtained via prescription for the copayment or coinsurance amount to apply. If Nicotine Replacement Therapy is purchased through the “Quit for Life” mail-order program, no copayment or coinsurance amount will apply.

The copayment or coinsurance amount specified in the “SCHEDULE OF BENEFITS” section applies for smoking cessation products (except NRT obtained through the “Quit for Life” mail-order program).

Spinal Manipulations/Chiropractic Services
Spinal Manipulations and mobilizations are considered Eligible Expenses when significant improvement can be expected within two months of commencement of such treatment and are subject to the Preferred Provider benefit level as shown in the “SCHEDULE OF BENEFITS” section. Chiropractic services provided by a chiropractor or Physician, such as X-rays, diagnostic tests, and hot/cold pack therapy used in conjunction with approved manipulation and mobilization, are also considered Eligible Expenses and are subject to the Non-Preferred Provider benefit level as shown in the “SCHEDULE OF BENEFITS” section.

Spinal Manipulations are subject to the Calendar Year maximum benefit shown in the “SCHEDULE OF BENEFITS” section.

Sterilization Procedures
Elective sterilization procedures, such as a tubal ligation, are considered Eligible Expenses. Vasectomies performed as an office procedure are also considered Eligible Expenses. Sterilization procedures for women intended for Contraceptive purposes only are considered Eligible Expenses under the preventive care services benefit. All sterilization procedures that are medical in nature and for non-Contraceptive purposes are subject to the appropriate deductible and/or copayment or coinsurance shown in the "SCHEDULE OF BENEFITS" section. Surgical procedures performed to reverse voluntary sterilization are not considered Eligible Expenses. (See also "Reversal of Sterilization" in the "PLAN EXCLUSIONS" section.)

Substance Use Disorder Detoxification
Acute inpatient Substance Use Disorder detoxification is considered an Eligible Expense if determined by a Physician that Outpatient management is not medically appropriate.

Temporomandibular Joint (TMJ) Disorder (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
Treatment of TMJ and other jaw joint disorders are considered Eligible Expenses. Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS" section. (See also "Mandibular and Maxillary Osteotomy" in this "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Urgent Care
Urgent care that requires immediate attention for an unforeseen Illness, Injury or condition to prevent serious deterioration is considered an Eligible Expense when services are provided in an urgent care center or Physician's office. An urgent care center also may be referred to as a convenient care center, prompt care center or express care center, and generally treats patients on a walk-in basis without a scheduled appointment. (See also "Foreign Travel" in the "PLAN EXCLUSIONS" section.)

Vision Care
Vision screenings and examinations for prescribing glasses, or for determining the refractive state of the eyes, are considered Eligible Expenses. For covered Dependent children under age 19 who are enrolled in the HMO Plan option, pediatric vision care is not considered an Eligible Expense.

One pair of eyeglasses or one contact lens per affected eye following cataract surgery is considered an Eligible Expense. The maximum allowable benefit for frames and lenses is the standard allowable established by the Centers for Medicare and Medicaid Services (CMS).

The Third Party Administrator maintains a list of eligible and excluded items and services and the maximum amount payable under this benefit. Benefits that are eligible under this Plan can be verified by calling the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

See also "Eyeglasses, Contacts and Refractory Treatment" in the "PLAN EXCLUSIONS" section.

Well-Child Care Services
Well-child care services for covered Dependent children are considered Eligible Expenses. Benefits include, but are not limited to, physicals and immunizations (that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the covered Dependent child involved). For covered Dependent children under age 19 who are enrolled in the HMO Plan option, pediatric vision care is not considered an Eligible Expense.

The following preventive care services for children are considered Eligible Expenses, in addition to any preventive care service already listed: (For a complete listing of services available under this preventive care services benefit, refer to the "EXHIBIT 1—BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS" section.)

- Autism screening for children at 18 and 24 months
- Behavioral assessments as part of preventive exams
- Dyslipidemia screening for children at higher risk of lipid disorders

- Fluoride chemoprevention supplements or varnish for children without fluoride in their water source
- Hearing screening for newborns
- Height, weight and body mass index as part of preventive exams for children
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- Lead screening for children who are at risk for exposure
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Tuberculin testing for children at higher risk of tuberculosis
- Congenital hypothyroidism screening for newborns
- Developmental screening for children under age three, and surveillance throughout childhood
- Vision screening for children

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service, then the Plan may use reasonable medical management techniques to determine any such benefit limitations.

PREAUTHORIZATION

When using Preferred Providers or Non-Preferred Providers, the Listed Services in the subsection "SERVICES REQUIRING PREAUTHORIZATION" must be Preauthorized to verify services are Medically Necessary and appropriate and considered Eligible Expenses under the Plan. Preauthorization must be initiated by calling (1) the telephone number listed on your Plan ID Card, or (2) the Utilization Review Manager listed in the "GENERAL PLAN INFORMATION" section of this document. If Preauthorization is not completed prior to receipt of the service, a Retrospective Review will be performed to determine Medical Necessity and appropriateness of any services obtained by a Non-Preferred Provider. If the service is deemed not Medically Necessary and appropriate, expenses incurred will be denied.

- **Preauthorization for PPO Plan Option and Qualified High Deductible Health Plan Option.** Covered Persons are responsible for ensuring that all Listed Services are Preauthorized by the Utilization Review Manager. If the Preauthorization request is approved, both the Covered Person and the Provider will be notified of the effective dates and the treatment and services for which benefits are authorized. Continuing care beyond the expiration date or number of approved visits in the initial Preauthorization request must be Preauthorized.

- **Preauthorization for POS Plan Option and HMO Plan Option.** The Covered Person's Primary Care Physician or participating Provider is responsible for obtaining Preauthorization from the Utilization Review Manager. If the Preauthorization request is approved, the Covered Person and the Primary Care Physician or participating Provider who requested the Preauthorization will be notified of the effective dates and the treatment and services for which benefits are authorized. If the Preauthorization request is denied, the Covered Person, the Primary Care Physician and the participating Provider will be notified in writing.

Preauthorization procedures are described in detail in the "HOW TO SUBMIT A CLAIM—CLAIMS REVIEW PROCEDURE" section.

Please note: Benefits under the Plan will not be provided for healthcare services that are not Medically Necessary and appropriate or if the Preauthorization request is denied.

EMERGENCY ADMISSION

If there is an **Emergency** admission to a Hospital, the patient, patient's family member or authorized representative, Hospital or attending Physician must contact the Utilization Review Manager **within 48 hours** of admission or as soon as possible after care begins.

In a Medical Emergency, a Covered Person may use Non-Preferred Providers and have benefits considered eligible by the Plan at the Preferred Provider level.

SERVICES REQUIRING PREAUTHORIZATION

PLEASE NOTE: This subsection contains two sets of Listed Services requiring Preauthorization. The first set of Listed Services requiring Preauthorization is effective through February 28, 2018; the second set of Listed Services requiring Preauthorization is effective March 1, 2018.

Through February 28, 2018: The following services (aka, "Listed Services") must be Preauthorized to be considered Eligible Expenses under the Plan:

- Abdominoplasty/Panniculectomy
- Acupuncture, Chiro, and Massage Therapy
- Ambulance—Air and Elective Ground
- Autologous Chondrocyte Transplant (ACT)/Implant (ACI), Osteochondral Autograft (OAT/mosaicplasty)
- Bariatric Surgery
- Blepharoplasty and Eye Brow Lift/Brow Ptotis
- Breast Reconstruction and Implant Removal and Replacement
- Cardiac Imaging and Procedures (ECHO, ECHO Stress, Cardiac Rhythm Implantable Devices, Myocardial Perfusion Imaging, Nuclear Medicine, Diagnostic Heart Catheterization)

- Clinical Trials, Phase I, II, III and IV
- Cochlear Implant
- Cosmetic and Reconstructive Surgery
- CyberKnife Stereotactic Radiosurgery
- Dental Services (if done in a facility)
- Durable Medical Equipment (select)
- Elective Inpatient Stays (all elective surgical and non-surgical inpatient admissions)
- Electrical Stimulation for Gastroparesis
- Endothelial Keratoplasty
- Endovenous Laser/RFA for Varicose Veins
- Experimental and Investigational Services
- Gender Dysphoria Procedures
- Genetic Testing/Procedures—All (including molecular diagnostics)
- Gynecomastia Surgery
- High Tech Imaging (CT, CTA, MRI, MRA, PET, 3D* [does not include 3D mammography])
- Home Health Services
- Hyperbaric Oxygen Therapy
- Infertility Services (all diagnostic tests, medications, treatments, etc.)
- Inpatient Rehabilitation Services
- Interstim: Implantable Sacral Nerve Stimulation for Urinary Dysfunction
- Interventional Pain Management
- Joint/Spine Surgery
- Laser Treatment of Psoriasis
- Lesions of the Skin and Soft Tissue (if done in a facility)
- Lumbar Fusion
- Meniscal Allograft Transplant
- OB and All Diagnostic Ultrasounds
- Observation Stays (notification is required for observation stays beyond 24 hours)
- Occupational, Physical and Speech Therapies
- Oncology Pathways
- Port Wine Stain Removal
- Private Duty Nursing
- Proton Beam Therapy
- Radiation Therapy
- Radiofrequency Facet Denervation for Back and Neck Pain
- Reduction Mammoplasty, female
- Scar Revision (if done in a facility)
- Skilled Nursing Facility
- Sleep Diagnostics, Evaluations and Supplies
- Specialty Pharmacy—All (including home infusion drugs)
- Spinal Cord Stimulator
- Testosterone, implantable
- Transplant Services
- Urgent Inpatient Stays (medical/surgical, Substance Use Disorder) notification is required (no review)

- Uvulopalatopharyngoplasty (UPPP)
- Vasectomy (if done in a facility)
- Vision Therapy

***** 3D mammography does not require Preauthorization.

Effective March 1, 2018 and after: The following services (aka, "Listed Services") must be Preauthorized to be considered Eligible Expenses by the Plan:

- Abdominoplasty/Panniculectomy
- Ambulance—Air and Elective Ground
- Autologous Chondrocyte Transplant (ACT)/Implant (ACI), Osteochondral Autograft (OAT/mosaicplasty)
- Bariatric Surgery
- Blepharoplasty and Eye Brow Lift/Brow Ptotis
- Breast Reconstruction and Implant Removal and Replacement
- Cardiac Imaging and Procedures (ECHO, ECHO Stress, Cardiac Rhythm Implantable Devices, Myocardial Perfusion Imaging, Nuclear Medicine, Diagnostic Heart Catheterization)
- Clinical Trials, Phase I, II, III and IV
- Cochlear Implant
- Cosmetic and Reconstructive Surgery
- CyberKnife Stereotactic Radiosurgery
- Dental Services (if done in a facility rather than in a Provider's office)
- Durable Medical Equipment (select)
- Elective Inpatient Stays (all elective surgical and non-surgical inpatient admissions)
- Electrical Stimulation for Gastroparesis
- Endothelial Keratoplasty
- Endovenous Laser/RFA for Varicose Veins
- Experimental and Investigational Services
- Gender Dysphoria Procedures
- Genetic Testing/Procedures—All (including molecular diagnostics)
- Gynecomastia Surgery
- Home Health Services
- Hyperbaric Oxygen Therapy
- Imaging (CT, CTA, MRI, MRA, PET, 3D* [does not include 3D mammography])
- Infertility Services (all diagnostic tests, medications, treatments, etc.)
- Inpatient Rehabilitation Services
- Interstim: Implantable Sacral Nerve Stimulation for Urinary Dysfunction
- Interventional Pain Management
- Joint Surgery—All
- Laser Treatment of Psoriasis
- Lesion Removal—Skin and Soft Tissue (if done in a facility rather than in a Provider's office)
- Meniscal Allograft Transplant
- Obstetrical and Diagnostic Ultrasound
- Observation Stays (notification is required for observation stays beyond 24 hours)
- Oncology Pathways
- Out-of-Network Referral for HMO

- Port Wine Stain Removal
- Private Duty Nursing
- Proton Beam Therapy
- Radiation Therapy
- Radiofrequency Facet Denervation for Back and Neck Pain
- Reduction Mammoplasty
- Rehabilitative Therapies**:**
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
- Scar Revision (if done in a facility)
- Skilled Nursing Facility
- Sleep Diagnostics, Evaluations and Supplies
- Specialty Pharmacy—All (including home infusion drugs)
- Spinal Cord Stimulator
- Testosterone, implantable
- Transplant Services
- Urgent Inpatient Stays (medical/surgical, Substance Use Disorder) notification is required (no review)
- Uvulopalatopharyngoplasty (UPPP)
- Vasectomy (if done in a facility)
- Vision Therapy

***** 3D mammography does not require Preauthorization.

PREAUTHORIZATION PENALTY

This Plan does not impose a Preauthorization penalty for failure to Preauthorize any of the Listed Services. A Retrospective Review will be performed to determine the Medical Necessity and appropriateness of any services obtained by a Non-Preferred Provider. If the service is deemed not Medically Necessary and appropriateness, expenses incurred will be denied.

CASE MANAGEMENT SERVICES

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. This is referred to as "case management." Case management shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Case management is a collaborative process and occurs when it will be beneficial to both the patient and the Plan.

A case manager consults with the patient (or the patient's authorized representative) and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient (or the patient's authorized representative). This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the patient's family to offer assistance and support;
- Monitoring the Hospital or Skilled Nursing Facility stay;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator/Plan Sponsor, attending Physician and patient (and/or the patient's authorized representative) must all agree to the alternative treatment plan.

Once agreement has been reached, the Plan Administrator/Plan Sponsor will direct the Plan to pay for Medically Necessary and appropriate services as stated in the treatment plan, even if these expenses normally would not be considered Eligible Expenses under the Plan. Unless specifically provided to the contrary in the Plan Administrator's/Plan Sponsor's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan provisions, limitations and cost sharing requirements.

Note: Case management is voluntary. There are no reductions of benefits or penalties if the patient (and/or the patient's authorized representative) chooses not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

For more information, contact the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this "DEFINED TERMS" section; however, some terms are defined within the provision the term is being used. Becoming familiar with the capitalized terms defined in this "DEFINED TERMS" section will help to better understand the provisions and limitations of this Plan.

Active Employee means an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center means a licensed facility that is used mainly for performing Outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorder.

Calendar Year means the 12-month period commencing January 1 and ending the following December 31.

Civil Union means a legal relationship granted to unmarried adult partners, of the same or opposite sex, by the State of Illinois. A substantially similar legal relationship (other than common-law marriage) legally entered into in another jurisdiction when recognized by the State of Illinois shall also be considered a Civil Union.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Contraceptive(s) means devices, drugs, procedures or other methods which are used to prevent Pregnancy or conception. Contraceptives do not include abortifacient drugs.

Covered Person means an Employee, IMRF Participant or Dependent who is covered under this Plan. In certain situations, a Covered Person also means a former Employee or former Dependent who is covered under this Plan.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing and/or feeding; or supervision over medication which could normally be self-administered.

Dependent means a child, or Spouse, Civil Union partner, or Domestic Partner of an Employee who meets the eligibility requirements of the Plan. The term "Dependent" also includes any person for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order.

Domestic Partner means an adult partner of the Employee of the same or opposite sex who live together in an exclusive, emotionally committed and financially responsible relationship and who meets the eligibility requirements of the Plan.

Durable Medical Equipment means equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of an Illness or Injury, and (4) is appropriate for use in the home.

Eligible Expense(s) means those expenses for Medically Necessary and appropriate services or supplies that are eligible under this Plan, subject to all Plan provisions, limitations and requirements.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing a person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act

(EMTALA)) within the capability of the Hospital emergency department. This includes routine ancillary services to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

"Stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. The term "Employee" also includes any person for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order.

Employer means any of the public agencies/educational institutions named as a "participant" in the Illinois Educators Risk Management Program Association Intergovernmental Cooperation Agreement which comprises the Illinois Educators Risk Management Program Association through which the Plan is established.

Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Essential Health Benefits means, to the extent they are considered Eligible Expenses under the Plan: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and Substance Use Disorder services and treatment (including behavioral health treatment), Prescription Drugs, rehabilitative and Habilitative Services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto. Based on the state benchmark plan selected by the Plan (as stated in the PPACA), Spinal Manipulations and Temporomandibular Joint (TMJ) Disorder are not considered Essential Health Benefits.

Family Unit means the covered Employee, the covered IMRF Participant and the family members who are covered as Dependents under this Plan. In certain situations, Family Unit also means the former Employee and the former family members who are covered as Dependents under this Plan.

Formulary means a list of safe, effective therapeutic drugs (prescription medications) specifically provided by this Plan.

Genetic Information means information about genes, gene products and inherited characteristics that may be derived from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. This definition also includes information derived from an individual's genetic tests; the genetic tests of the individual's family members (first- through fourth-degree relatives); and the manifestation of a condition in the individual's family members. Genetic information also includes the individual's request for, receipt of, or participation in, clinical research for genetic services (tests, counseling and education) and PKU, BRCA1 or BRCA2 tests.

With respect to a Pregnant woman (or the Pregnant individual's family members), genetic information specifically includes information about the fetus she is carrying or any embryo legally held by the individual or a family member.

Genetic information does not include information about an individual's sex or age, a manifested condition that could reasonably be diagnosed by a medical professional, or analysis of proteins or metabolites directly related to a manifested condition.

Habilitative Services means healthcare services that help a person keep, learn or improve skills and functioning for daily living as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a Dependent child who is not walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a congenital, genetic or early acquired disorder. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or Outpatient settings.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Hospice Care Program means a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of a terminally ill Covered Person and his or her family, by providing palliative and supportive

medical, nursing and other services through at-home or inpatient care.

Hospital means an institution that meets the following requirements: it must provide medical and surgical care and treatment for acutely sick or Injured persons on an inpatient basis; it must have diagnostic and therapeutic facilities; care and treatment must be given by or supervised by Physicians; day and night nursing services must be given and supervised by a licensed nurse; it must not be operated by a national, provincial or state government; it must not be primarily a place of rest, a place for the aged or a nursing home; and it must be licensed by the laws of the jurisdiction where it is located and operated as a Hospital as defined by those laws.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

IMRF Participant means a former Active Employee of the Employer who:

(1) is removed from the Employer's payroll due to retirement or disability and immediately becomes entitled to receive an IMRF pension or disability benefit under the formal, written procedures of the IMRF; and

(2) has elected to pay 100 percent of the cost of Plan coverage.

Infertility means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to sustain a successful Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Late Enrollee means an Employee or Dependent who enrolls in the Plan other than during the first 31-day period in which the individual is eligible to enroll in the Plan, or during a Special Enrollment Period.

Legally Separated or Legal Separation means an arrangement to remain married but live apart, following a court order.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime means a word that appears in this Plan in reference to benefit maximums and limitations. The term "Lifetime" is understood to mean "while covered under this Plan." Under no circumstances does Lifetime mean "the duration of the lifetime of the Covered Person."

Listed Services means the specified services outlined in the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section of this Plan that require Preauthorization **in advance** of the Covered Person receiving the services from the Provider.

Maximum Allowable Charge means the greatest fee the Plan will analyze and consider to determine benefits for services provided by a Non-Preferred Provider and generally is based on the lesser of one of the following:

(1) The fee charged by the Non-Preferred Provider for the service rendered;

(2) The fee that has been negotiated with the Provider for the services, whether directly or through one or more intermediaries, or shared savings contracts;

(3) The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area;

(4) The fee based on 150 percent of the Medicare reimbursement as determined by the fee Medicare allows for the same or similar services provided in the same geographic area;

(5) The allowed expense for a Preferred Provider for the same or similar service; or

(6) The Usual, Customary and Reasonable Charge.

Medical Director means a licensed Physician who is employed by or contracts with the Third Party Administrator to

provide services including, but not limited to, Preauthorization, utilization management and quality assurance reviews.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary means care, treatment or supply recommended or approved by a Physician or dentist; is consistent with the patient's condition and accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. When applied to inpatient care, it further means that the patient's medical symptoms or condition require that the services cannot be safely provided to the patient on an Outpatient basis.

All of the above criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary and appropriate.

The Plan Administrator/Plan Sponsor or its designee has the discretionary authority to decide if care or treatment is Medically Necessary and appropriate.

Medicare means the Health Insurance for the Aged and Disabled program established by Parts A and B of Title XVIII of the Social Security Act, as amended (42 U.S.C. 1395 et seq.).

Medicare-Eligible Beneficiary means a beneficiary who is eligible for Medicare due to age, disability or end-stage renal disease, whether or not the beneficiary enrolls in Medicare.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Preferred Provider means a Physician or Provider who has not entered into a valid contract to provide healthcare services to Covered Persons.

Outpatient means the care or services received in a Physician's office, the Outpatient department of a Hospital, an Ambulatory Surgical Center, a medical center, an X-ray or laboratory facility, a retail Pharmacy or the Covered Person's home.

Patient Protection and Affordable Care Act of 2010 (PPACA) means the Patient Protection and Affordable Care Act of 2010 (PPACA) (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). The PPACA is also commonly referred to as the "Affordable Care Act" or "Health Care Reform."

Pharmacy means a licensed establishment where eligible Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a person licensed to practice medicine in all of its branches under the applicable laws of the state where he or she practices.

Plan means Illinois Educators Risk Management Program Group Health Plan, which is a benefit plan for certain Employees, former Employees and IMRF Participants of the public agencies/educational institutions named as a "participant" in the Illinois Educators Risk Management Program Association Intergovernmental Cooperation Agreement which comprises the Illinois Educators Risk Management Program Association and is described in this document.

Plan ID Card means a card that is provided to each Covered Person upon enrollment in the Plan for identification purposes. Possession of a Plan ID Card confers no right to Plan benefits. Replacement cards may be requested by contacting the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

Plan Year means the 12-month period beginning on the effective date of the Plan (or, if the first Plan Year is a short Plan Year, beginning on the day following the end of the first Plan Year) and each anniversary thereof.

Preauthorization (Preauthorized) means the review to determine and authorize the benefit level of Medically Necessary and appropriate services and supplies the Plan will consider eligible if authorized prior to receiving the services/supplies.

Preferred Provider means a Physician or Provider that has entered into a valid contract to provide healthcare services to Covered Persons.

Pregnancy means childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend "Caution: federal law prohibits dispensing without a prescription"; injectable insulin; and hypodermic needles or syringes (but only when dispensed upon a written prescription of a licensed Physician). Such drug must be Medically Necessary and appropriate in the treatment of an Injury or Sickness.

Primary Care Physician means a Preferred Physician who spends a majority of clinical time engaged in general practice, family practice, or in the practice of internal medicine, gynecology, obstetrics or pediatrics.

Provider means an individual or organization licensed to provide healthcare services under the applicable laws of the state where they provide services.

Retrospective Review means a review performed after a claim for benefits is received.

Sickness means a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility means a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse (R.N.). Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse (R.N.).

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, those with mental retardation, Custodial or educational care, or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to expenses incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute-care facility or any other similar nomenclature.

Specialty Prescription Drug means any agent that is obtained from a specialty drug Provider because of special handling, storage, administration, monitoring and/or financial requirements.

Specialty Prescription Drugs are further defined as any Prescription Drug, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and are identified as a Specialty Prescription Drug on the Formulary: (a) specialized procurement handling, distribution or administration in a specialized fashion; (b) complex benefit review to determine coverage; (c) complex medical management; or (d) FDA-mandated or evidence-based, medical-guideline determined, comprehensive patient and/or Physician education.

Spinal Manipulation means skeletal adjustments, manipulation or other treatment in connection with the detection and

correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is rendered by a Physician or chiropractor to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means an individual who is recognized as the covered Employee's lawful husband or wife, including partners in a Civil Union. The term "Spouse" does not include partners in a common-law marriage or a domestic relationship. The Plan Administrator/Plan Sponsor may require documentation proving a legal marital relationship.

Substance Use Disorder means the uncontrollable and/or excessive abuse of addictive substances and the resultant physiological or psychological dependence that develops with continued use and for which treatment is Medically Necessary and appropriate. The addictive substances included under Substance Use Disorder are limited to alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

Third Party Administrator means a person, employer of persons or other entity appointed and authorized by the Plan Administrator/Plan Sponsor which provides customer service and processes claims for benefit payments under the Plan and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator provides any other services with respect to the administration of the Plan as the Plan Administrator/ Plan Sponsor may request and/or delegate and that the Third Party Administrator agrees to perform. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator/Plan Sponsor. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan. See the "GENERAL PLAN INFORMATION" section of this Plan for the Third Party Administrator's contact information.

Total Disability (Totally Disabled) means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. In the case of an individual who is blind, Total Disability means the inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity he or she has previously engaged in with some regularity and over a substantial period of time.

Usual, Customary and Reasonable Charge means a charge which is not higher than the usual charge made by Providers and does not exceed the usual charge made by most Providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. Eligible Expenses incurred from Preferred Providers are not subject to Usual, Customary and Reasonable Charge limitations because of contractual provisions.

The Plan will reimburse the actual charge billed if it is less than the Usual, Customary and Reasonable Charge.

The Plan has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.

Utilization Review Manager means a team of medical care professionals selected to conduct Preauthorization review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. See the "GENERAL PLAN INFORMATION" section of this Plan for the Utilization Review Manager's contact information.

Waiting Period means the period that must pass before coverage for an Employee or Dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drug Benefits are shown in the "PRESCRIPTION DRUG BENEFITS" section.

For all medical benefits shown in the "SCHEDULE OF BENEFITS" section, expenses incurred for the following are not considered Eligible Expenses:

Abortion
Expenses incurred for and in connection with an abortion are not considered Eligible Expenses, unless the life or physical health of the mother is in imminent danger.

Acupuncture, Acupressure and Hypnotherapy
Expenses incurred for treatment and services related to acupuncture, acupressure and hypnotherapy are not considered Eligible Expenses.

Bariatric Surgery (Applies only to Covered Persons enrolled in the HMO Plan Option)
Bariatric surgery for the treatment of severe obesity is not considered an Eligible Expense. (See also "Bariatric Surgery (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Blood Processing
Costs related to the processing and storage of blood and its components from a person designated as a donor are not considered Eligible Expenses.

Circumstances Beyond the Control of the Plan
To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of the Plan results in the facilities, personnel or financial resources of the Plan or any of the Preferred Providers being unavailable to provide or arrange for the provision of an eligible service, the Plan is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event.

Complications of Excluded Treatments
Care, services or treatment required as a result of complications from a treatment that is excluded under the Plan are not considered Eligible Expenses.

Convenience or Comfort Items
Convenience or comfort items are not considered Eligible Expenses. These items include, but are not limited to, grab bars, tub transfers, seat lifts, raised toilet seats, telephones and televisions.

Cosmetic Surgery
Surgery for cosmetic purposes and not primarily for reasons of Medical Necessity is not considered an Eligible Expense. This includes, but is not limited to, rhinoplasties, breast reductions, blepharoplasties, liposuction and removal of skin tags and lipomas when not done primarily because of Medical Necessity. (See also "Reconstructive Surgery" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Counseling
Expenses incurred for social counseling or marital counseling are not considered Eligible Expenses.

Custodial or Convalescent Care
Custodial or convalescent care in an acute general Hospital, Skilled Nursing Facility or home is not considered an Eligible Expense.

Dental Services
Dental services are not considered Eligible Expenses unless otherwise specifically addressed in this Plan. Surgical removal of wisdom teeth and services related to Injuries caused by or arising out of the act of chewing are also not considered Eligible Expenses. Hospitalizations for dental work are not considered Eligible Expenses unless the hospitalization is necessary due to a medical condition and is Preauthorized by a Medical Director. Pediatric dental

services are not considered Eligible Expenses for Covered Persons enrolled in the HMO Plan Option. (See "Oral Surgery" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Disposable Items
Self-administered dressings and other disposable supplies are not considered Eligible Expenses. (See also "Durable Medical Equipment and Orthopedic Appliances" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Durable Medical Equipment, Orthopedic Appliances and Devices
The following corrective and orthopedic appliances and devices are not considered Eligible Expenses: earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges. Wheelchairs (manual or electric) and lift chairs are not considered Eligible Expenses, unless the Covered Person would be bed- or chair-confined without such equipment. This includes any dispensing fees incurred in obtaining these items. (See also "Durable Medical Equipment and Orthopedic Appliances" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Erectile Dysfunction (Applies only to Covered Persons enrolled in the HMO Plan Option)
All forms of treatment (medical or surgical) for erectile dysfunction or impotence are not considered Eligible Expenses. (See also "Erectile Dysfunction (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Experimental Treatments/Procedures/Drugs/Devices/Transplants
Unless otherwise stated in this Plan Document/Summary Plan Description (""see "Clinical Trials" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section), the Plan does not consider eligible any expenses incurred for or related to any medical treatment, procedure, drug, device or transplant that is determined by a Medical Director to meet one or more of the following standards or conditions:

(1) The medical treatment, procedure, drug, device or transplant that is under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for a condition, disease or Illness.

(2) The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies or clinical trials are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for a condition, disease or Illness.

(3) The drug or device cannot be lawfully marketed for a condition, disease or Illness without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.

(4) The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a condition, disease or Illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

(5) The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a condition, disease or Illness is determined by a Medical Director to be experimental or investigational.

In making his or her determination that a medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a condition, disease or Illness is excluded from being considered an Eligible Expense under the Plan, a Medical Director will use current medical literature, discussion with medical experts and other technological assessment bodies designated by the Third Party Administrator. Each review will be on a case-by-case basis regarding benefits for a requested medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a Covered Person's condition, disease or Illness.

Eyeglasses, Contacts and Refractory Treatment
Eyeglasses, contact lenses, contact lens evaluations and fittings are not considered Eligible Expenses, unless there is a diagnosis of cataract. (See "Vision Care" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.) Lens tinting, scratch-protection coating, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses are not considered Eligible Expenses. Refractive eye surgery including, but not limited to, refractive keratectomy, radial keratotomy and laser-assisted *in-situ* keratomileusis (LASIK) surgery, is not considered an Eligible Expense.

Fitness
Any program designed for overall physical fitness or membership to fitness facilities for the same purpose is not considered an Eligible Expense. Rehabilitative therapy is not included in this exclusion.

Foot Care
Care for weak, unstable or flat feet, or bunions is not considered an Eligible Expense, unless an open cutting operation is performed, or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed. The purchase of orthopedic shoes, shoe inserts, wedges, heel cups or other devices for support of the feet (except for Medically Necessary custom-molded foot orthotics) are not considered Eligible Expenses.

Foreign Travel
Expenses incurred outside of the United States of America are not considered Eligible Expenses if (1) the Covered Person traveled to such location(s) to obtain medical services, drugs or supplies; or (2) such services, drugs or supplies are unavailable or illegal in the United States of America.

Genetic Testing (Applies only to Covered Persons enrolled in the HMO Plan Option)
Genetic testing for individuals from the general population at average risk is not considered an Eligible Expense. Selected high-risk patients may benefit from screening for certain diagnoses (e.g., breast cancer, cystic fibrosis, hemoglobin disorders) when medical criteria has been met. (See also "Genetic Testing (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Governmental Responsibility
Care for disabilities connected to military service for which the Covered Person is legally entitled to services and for which facilities are reasonably available, or for conditions that state or local laws require be treated in a public facility, unless legal liability exists, are not considered Eligible Expenses.

Hair Loss
Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, are not considered Eligible Expenses.

Hearing Aids
Hearing aids, their fittings or testing for the purpose of using a hearing aid are not considered Eligible Expenses. Any service, supply or treatment for the rehabilitation of hearing impairment is also not considered an Eligible Expense.

Hearing Evaluations (Applies only to Covered Persons enrolled in the HMO Plan Option)
Hearing evaluations are not considered Eligible Expenses. (See also "Habilitative Services" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Home Health Services (Applies only to Covered Persons enrolled in the HMO Plan Option)
Home health services are not considered Eligible Expenses. . (See also "Home Health Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Home Infusion Services (Applies only to Covered Persons enrolled in the HMO Plan Option)
Hearing infusion services are not considered Eligible Expenses. (See also "Home Infusion Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Human Organ Donor
When a Covered Person serves as the organ donor for a non-covered recipient, organ donor treatment or services are not considered Eligible Expenses. This includes the expenses incurred related to the procurement of an organ or tissue.

Illegal Activities
Expenses incurred for any service, supply or treatment that arose out of or occurred while engaged in any illegal or criminal enterprise or activity are not considered Eligible Expenses. This exclusion does not apply if the Injury or

Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)
The following Infertility services are not considered Eligible Expenses:

- Payment for services rendered to a surrogate; however, costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be considered Eligible Expenses if the individual chooses to use a surrogate;
- Costs associated with cryopreservation and storage of sperm, eggs and embryos; however, costs associated with subsequent procedures of a medical nature necessary to make use of the cryopreserved substance are considered Eligible Expenses if the procedures are not deemed to be experimental and/or investigational;
- Non-medical costs of an egg or sperm donor;
- Travel costs associated with Infertility treatment;
- Selective termination of an embryo;
- Drugs associated with excluded Infertility services;
- Reversal of a voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits are considered Eligible Expenses if the Covered Person's diagnosis meets the definition of "Infertility" as specified in the "DEFINED TERMS" section. Benefits are not provided for the diagnostic services needed to confirm a successful reversal;
- Infertility treatments rendered to covered Dependents under the age of 18;
- Donor embryos;
- Infertility services that are deemed to be experimental or investigational as supported by the written determination of the American Society for Reproductive Medicine or the American College of Obstetrics; however, Infertility treatment that includes services or treatments that are not experimental in nature and can be delineated and separately charged from Infertility treatment considered experimental are considered Eligible Expenses; and
- Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

See also "Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.

Infertility Services (Applies only to Covered Persons enrolled in the HMO Plan Option)
Infertility services are not considered Eligible Expenses under the Plan. (See also "Infertility Services (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Institutional Care
Institutional care for the primary purpose of controlling or changing a Covered Person's environment, or is maintenance care, Custodial Care, domiciliary care, convalescent care or rest care is not considered an Eligible Expense.

Mandibular and Maxillary Osteotomy (Applies only to Covered Persons enrolled in the HMO Plan Option)
Mandibular and maxillary osteotomy services are not considered Eligible Expenses. (See also "Mandibular and Maxillary Osteotomy (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP) option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Medicare Benefits
If a Covered Person is eligible for Medicare as their primary coverage, but not enrolled in Medicare, benefits under this Plan are reduced by the amount Medicare would have paid, regardless if such benefits are actually received from Medicare.

Obesity
Expenses incurred for special formulas, food supplements, special diets, minerals, vitamins or Physician and non-Physician supervised weight loss programs are not considered Eligible Expenses. Treatment or products for obesity, food addiction or weight reduction are not considered Eligible Expenses. (See "Bariatric Surgery" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Outpatient Prescription Drugs
Outpatient Prescription Drugs are not considered Eligible Expenses. (See the "PRESCRIPTION DRUG BENEFITS" section.)

Private Duty Nursing
Expenses incurred in connection with care, treatment or services of a private duty nurse are not considered Eligible Expenses.

Reversal of Sterilization
A surgical procedure to reverse voluntary sterilization and any resulting Infertility services are not considered Eligible Expenses. (See also "Sterilization Procedures" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Services That Are Not Medically Necessary
Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage are not considered Eligible Expenses.

Vocational rehabilitation services or other services or supplies that are not Medically Necessary or appropriate for the treatment, maintenance or improvement of a Covered Person's health, are not considered Eligible Expenses.

Services That Are Not Primarily Medical in Nature
Services that are not primarily medical in nature are not considered Eligible Expenses, including, but not limited to, traditional mattresses, air filters, Jacuzzis/spas, swimming pools, exercise equipment, gym memberships, air conditioners, adaptive devices/filters for residential heating and air conditioning systems, car seats, and educational services.

Sex Changes and Sex Therapy
Expenses incurred for any service, supply or treatment for a sex change or sex therapy are not considered Eligible Expenses.

Skin Lesions
Skin lesion removal primarily for cosmetic reasons rather than for Medical Necessity is not considered an Eligible Expense.

Speech Therapy
Any service, supply or treatment for speech therapy connected with a learning disability, developmental disorder or functional nervous disorder is not considered an Eligible Expense. Therapy for conditions when improvement is not anticipated within two months of commencement is also not considered an Eligible Expense. (See also "Rehabilitation and Skilled Nursing Care—Inpatient" and "Rehabilitative Therapy Services—Outpatient" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Supplemental Drinks/Vitamins/Weight Gain Products
Over-the-counter supplies or products taken to supplement caloric intake, not primarily medical in nature and not used as the sole source of nutrition, are not considered Eligible Expenses.

Temporomandibular Joint (TMJ) Disorder (Applies only to Covered Persons enrolled in the HMO Plan Option)
Any service, supply or treatment connected with TMJ pain or other jaw joint disorders is not considered an Eligible Expense. (See also "Mandibular and Maxillary Osteotomy (Applies only to Covered Persons enrolled in the following Plan options: Preferred Provider Organization (PPO) Plan option, Qualified High Deductible Health Plan (QHDHP)

option or the Point-of-Service (POS) Plan option.)" in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.)

Travel or Accommodations
Expenses incurred for travel or accommodations are not considered Eligible Expenses, whether or not recommended by a Physician, unless otherwise specifically stated in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section.

Other Excluded Expenses

(1) Any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.

(2) Any service, supply, treatment, diagnosis or advice for which the Covered Person is not legally required to pay.

(3) Any service, supply or treatment prohibited by the laws of the United States of America or the state where the expense was incurred.

(4) Any care, treatment, service or supply furnished by a facility owned and/or operated by a state or national government, unless the Covered Person is legally obligated to pay for the care or treatment or if the United States of America has the authority to recover or collect the reasonable cost of such care or service.

(5) Any Injury or Illness arising out of, or occurring in the course of, the Covered Person's job for wage or profit which is covered by workers' compensation or similar law.

(6) Expenses incurred for appointments scheduled and not kept (missed appointments) or for the preparation of medical abstracts or completion of claim forms.

(7) Expenses incurred before the Covered Person's coverage goes into effect or after termination from the Plan.

(8) Services provided by a non-licensed professional.

(9) Care ordered or directed by individuals other than a Physician or registered clinical psychologist.

(10) Court-ordered evaluations or treatment, care in lieu of detention or correctional placement or family retreats.

(11) Services furnished or billed by a Provider that has been excluded or debarred by the federal government.

(12) Services and supplies not specifically mentioned in this Plan Document/Summary Plan Description.

PRESCRIPTION DRUG BENEFITS

Outpatient Pharmacy benefits are administered through a national Pharmacy Benefit Manager. Many independent Pharmacies and most national chains are considered Preferred Pharmacies. To find out if a Pharmacy is a Preferred Pharmacy, call the Third Party Administrator's Customer Service Department at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

Prescription Drugs and supplies are considered Eligible Expenses when dispensed by a Preferred Pharmacy or a Non-Preferred Pharmacy and prescribed by a Physician in connection with Medically Necessary and appropriate services and supplies.

ELIGIBLE PRESCRIPTION DRUG EXPENSES

Prescription Drugs that are considered Eligible Expenses under this Plan include the following:

- Drugs prescribed by a Physician that require a prescription either by federal or state law, but excluding any drugs specified as excluded expenses under this Plan.

- Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

- Glucagon emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar and test strips for glucose monitors, when obtained with a prescription from a Physician.

- Syringes, when the injectable drug is considered an Eligible Expense.

- Contraceptives for women, including but not limited to, oral Contraceptives (birth control pills), patches, the ring, and all FDA-approved, over-the-counter (OTC) Contraceptive products (including, but not limited to: cervical cap, condoms, emergency Contraceptives, sponges and spermicide), with a prescription from a Physician.

  If a generic version of a Prescription Drug is not available, or would not be medically appropriate for the Covered Person as a prescribed brand-name Contraceptive method (as determined by the attending Provider, in consultation with the patient), then benefits will be provided for the brand-name drug expenses, without cost-sharing, and may be subject to reasonable medical management.

- Prescription Drugs for the treatment of a dental condition.

- Prescription Drugs for the treatment of Infertility.

- Prenatal and infant prescription vitamins.

- Prescription-prescribed aspirin (generic only) to prevent cardiovascular disease (CVD) in adult Covered Persons (quantity limitations will apply).

- Vitamin D supplements when prescribed for fall prevention.

- **Reversal Agent or Antidote for Opioid Overdose.** Generic (Tier 1) naloxone intramuscular injections only.

- **Smoking Cessation Pharmacological Therapy.** Smoking cessation pharmacological therapy, as specified on the Formulary, when the Covered Person is enrolled in the "Quit for Life" smoking cessation program. The retail Prescription Drug copayment or coinsurance applies.

- **Specialty Prescription Drugs.** Specialty Prescription Drugs, as specified on the Formulary, are available from a specialty Pharmacy vendor. Benefits are subject to a prior written order by your Physician.

  The Tier 4, Tier 5 and/or Tier 6 copayments or coinsurance apply as specified in the "SCHEDULE OF BENEFITS" section. Tier 4 Specialty Prescription Drugs are the most clinically and cost effective. These are known as Preferred Specialty Drugs. Tier 5 Specialty Prescription Drugs have a higher cost than the Tier 4 Specialty Prescription Drugs and usually have clinically comparable alternatives available at the Tier 4 benefit

level. These are known as Non-Preferred Specialty Drugs. Tier 6 Specialty Prescription Drugs have the highest cost and are drugs that may not have the clinical advantages of Tier 4 or Tier 5 Specialty Drugs. The three-tier system helps manage costs, but provides flexibility and benefits for Covered Persons who choose a higher-tiered drug.

Certain Prescription Drugs, referred to as Medical Specialty Prescription Drugs, are considered Eligible Expenses under the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section of this document.

- **Immunosuppressant Drugs to Prevent Organ or Tissue Rejection.** A prescription for an immunosuppressant drug to prevent rejection of a transplanted organ or tissue, which indicates "may not substitute" on the prescription, must be filled as written. However, a substitution may be made, provided the prescribing Physician and the patient (or parent or guardian if the patient is a child) or the Spouse or Domestic Partner of a patient who is authorized to consent to the treatment of the person:

  - has been properly notified; and
  - documented consent is received.

  Any applicable copayment, deductible, coinsurance or other charge shall remain the same for the Calendar Year, unless another drug or formulation has been interchanged.

  The Covered Person and his or her Physician shall be notified, in writing, at least 60 days prior to any Formulary change that alters the terms of coverage or the discontinuance of coverage for a prescribed immunosuppressant drug that a patient is receiving. The written notification may be provided when the patient requests a refill along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

COPAYMENTS, COINSURANCE AND DISPENSING LIMITATIONS

- Prescription Drug and Specialty Prescription Drug benefits under the QHDHP option are subject to the Calendar Year deductibles specified in the "SCHEDULE OF BENEFITS" section. Covered Persons enrolled in the QHDHP option are required to pay 100 percent of their Prescription Drug and Specialty Prescription Drug expenses until the Calendar Year deductible has been satisfied.

- Initial prescriptions and prescription refills are limited to the maximum supply shown in the "SCHEDULE OF BENEFITS" section.

- The lesser of the Pharmacy's regular charge for the drug or the copayment or coinsurance specified in the "SCHEDULE OF BENEFITS" section is paid for each initial prescription or prescription refill.

- Most generic drugs will be dispensed under the Tier 1 copayment or coinsurance. If a brand-name drug is requested by the Covered Person or his or her Physician when a generic form of the drug exists, the Covered Person will pay the Tier 1 copayment or coinsurance plus the difference in cost between the Tier 2 or Tier 3 drug, whichever is dispensed.

- If a Tier 2 or Tier 3 drug is prescribed and a generic form of the drug does not exist, the Tier 2 or Tier 3 copayment or coinsurance applies.

- If a Tier 5 or Tier 6 drug is prescribed and a generic form of the drug does not exist, the Tier 5 or Tier 6 copayment or coinsurance applies.

- Certain brand-name drugs will be dispensed at the Tier 2 or Tier 3 copayment or coinsurance, even when a generic equivalent is available, when requested by a Physician. In this instance, only the Tier 2 or Tier 3 copayment or coinsurance applies. These drugs include, but are not limited to, Tegretol®, Lanoxin®, Dilantin®, Coumadin® and Ritalin®, and are subject to change.

- The copayment or coinsurance shown in the "SCHEDULE OF BENEFITS" section applies to each manufacturer's standard package based on the written prescription, including but not limited to: topical cream, solution, gel or ointment, otic, ophthalmic or nasal preparation, nasal or oral inhaler, three (10ml) vials of insulin or antibiotic suspensions.

- A 90-day supply of maintenance medications may be obtained at certain Preferred retail Pharmacies. For a list of these Pharmacies, contact the Pharmacy Benefit Manager at the telephone number listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document.

- When requesting prescriptions by mail-order, the prescription, an order form and the mail-order copayment or coinsurance must be mailed to the mail-order Pharmacy service. One mail-order copayment or coinsurance will apply to any number of 'days' supply up to a 90-day supply. Prescriptions for less than a 90-day supply should be filled at a Preferred or Non-Preferred Outpatient Pharmacy.

Your Plan ID Card must be presented for each prescription purchase. This card contains information needed to process prescriptions for payment to the Pharmacy. The copayment or coinsurance is required to be paid when the prescriptions are filled. If your Plan ID Card is not presented, the full retail price of the prescription may be required to be paid. To request reimbursement, submit the itemized receipt, along with a reimbursement request form, to the Pharmacy Benefit Manager's address listed on your Plan ID Card or in the "GENERAL PLAN INFORMATION" section of this document. Forms are available upon request from the Third Party Administrator or the Pharmacy Benefit Manager.

PRESCRIPTION DRUG FORMULARY

A Prescription Drug Formulary, which is a list of preferred Tier 1, Tier 2 and Tier 3 drugs, as well as Tier 4, Tier 5 and Tier 6 Specialty Prescription Drugs, has been developed by the Pharmacy Benefit Manager. The drugs listed on the Formulary are reviewed and revised periodically by the Health Alliance Pharmacy and Therapeutics Committee. Contracts with certain drug manufacturers may include rebate programs. The drug Formulary is available on the Pharmacy Benefit Manager's website and any changes to the Formulary are posted on the website (the website is listed in the "GENERAL PLAN INFORMATION" section of this document). Upon request, the Pharmacy Benefit Manager will provide information as to whether a Prescription Drug is included in the Formulary.

PRESCRIPTION REFILL SYNCHRONIZATION

Prescription refill synchronization is the allowance to refill one or more maintenance medication(s) on the same day to eliminate the need for multiple trips to the Pharmacy for easier management of medications.

The Covered Person's cost sharing amount will be adjusted based on the quantity of medication filled for the purpose of synchronization of medications. A daily proration cost sharing amount would be charged to accommodate medication synchronization.

Schedule II, III or IV controlled substances, drugs that have special handling or sourcing needs that require a single designated Pharmacy to fill or refill the prescription, and drugs that cannot be safely split into short-fill periods to achieve synchronization are excluded from refill synchronization.

If the Covered Person has multiple prescriptions filled at different times and would like to sync them to be able to fill them at the same time each month, he or she may contact the Pharmacy Benefit Manager at the phone number listed on the Plan ID Card.

PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION

Some Prescription Drugs require Preauthorization from the Pharmacy Benefit Manager and certain criteria to be met. Drugs that require Preauthorization are noted on the Prescription Drug Formulary. The Covered Person's Physician must contact the Pharmacy Benefit Manager to obtain Preauthorization. To conform with changes in medical technology, the Pharmacy Benefit Manager will maintain a list of pharmaceuticals that require Preauthorization. This list is available upon request. Failure to obtain Preauthorization may result in denial of benefits for the Prescription Drug. New drugs require Preauthorization for at least six months from the date of launch until the drugs have undergone review by the Health Alliance Pharmacy and Therapeutics Committee.

Preauthorization procedures are described in detail in the "HOW TO SUBMIT A CLAIM—CLAIMS REVIEW PROCEDURE" section of this document.

PHARMACY SAVINGS PROGRAMS

Retail 90 Program. The Retail 90 program allows Covered Persons to purchase certain maintenance medications used to

treat common conditions such as asthma, high cholesterol, high blood pressure and diabetes at a discounted cost. The Health Alliance Pharmacy and Therapeutics committee determines the medications eligible for this value-based benefit based on the value they have for keeping the individual healthy. Because this is a voluntary program designed to increase flexibility, Covered Persons who prefer may continue purchasing the traditional 30-day supply from their Pharmacy subject to the regular copayment or coinsurance as specified in the "SCHEDULE OF BENEFITS" section.

A listing of the medications included in the Retail 90 program is available on the Pharmacy Benefit Manager's website or by calling the Pharmacy Benefit Manager. The website and telephone number are listed in the "GENERAL PLAN INFORMATION" section of this document.

$R_x$tra Program.(This program will be discontinued as of January 1, 2019.) The Pharmacy Benefit Manager has entered into agreements with certain Preferred Pharmacies to provide Covered Persons an opportunity for additional savings. Certain Prescription Drugs, when purchased at an $R_x$tra Preferred Pharmacy or an $R_x$tra Preferred Plus Pharmacy, are available at no cost to the Covered Person. In addition, certain cholesterol and asthma medications (e.g. Albuterol Sulfate 90 Mcg; Pravastatin Sodium 10 Mg; Simvastatin 40 Mg) are available at no cost when purchased at an $R_x$tra Preferred Plus Pharmacy.

Please note: The benefits outlined above apply to each 30-day supply of the medications available in the $R_x$tra program.

If a prescription is filled at a Pharmacy that is not participating in the $R_x$tra program, the Covered Person must pay the applicable copayment or coinsurance as listed in the "SCHEDULE OF BENEFITS" section.

Additional information about the $R_x$tra program, the medications included in the $R_x$tra program and the participating Pharmacies is available on the 'Third Party Administrator's website, or by calling the Pharmacy Benefit Manager or visiting their website. The website and telephone number are listed in the "GENERAL PLAN INFORMATION" section of this document.

EXCLUDED PRESCRIPTION DRUG EXPENSES

The following items are not considered Eligible Expenses under the Plan:

- Prescription Drugs for treatment of erectile dysfunction.
- Non-prescription medications, except for diabetic supplies that are considered Eligible Expenses and a limited number of over-the-counter (OTC) medications.
- When a medication is available both by prescription (federal legend) and as an OTC product, the Prescription Drug is not considered an Eligible Expense.
- Prescription Drugs not considered Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by the Pharmacy Benefit Manager, including, but not limited to: BOTOX®, psoralens, tretinoin and oral antifungal agents for cosmetic use, anorexiants or weight loss medications, anabolic steroids, oral fluoride preparations, and hair removal or hair growth-promoting medications.
- Devices of any type, even if such devices may require a prescription including, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, support garments, bandages, etc.
- Any drug labeled, "Caution – Limited by Federal Law to Investigational Use," or experimental or other drugs prescribed for unapproved uses. Prescription Drugs for cancer treatment are considered Eligible Expenses if the drug is approved by the U.S. Food and Drug Administration (FDA) and is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: the American Medical Association Drug Evaluations; the American Hospital Preferred Service Drug Information; or the United States Pharmacopeia Drug Information; or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States of America or Great Britain.
- Prescription Drugs for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency, or any medication furnished by any other drug or medical service for which there is no charge.

- Any expense incurred for the administration of a drug.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Any drug determined to be abused or otherwise misused by a Covered Person.

LIMITS TO THIS BENEFIT

Certain Prescription Drugs may be subject to drug limitations based on FDA-approved dosage recommendations. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be provided only if the Plan Administrator/Plan Sponsor decides in its discretion that a Covered Person is entitled to them.

Send Claims to the Third Party Administrator at the address specified in the "GENERAL PLAN INFORMATION" section of this Plan Document/Summary Plan Description.

See the "PRESCRIPTION DRUG BENEFITS" section for reimbursement of Pharmacy benefits through the Pharmacy Benefit Manager.

WHEN CLAIMS SHOULD BE FILED

Preferred Provider Claims—Claims should be filed within 90 days of the date the expenses for the services were incurred. Benefits are based on the Plan's provisions at the time the expenses were incurred. Claims filed later than that date may be declined or reduced unless:

(1) it's not reasonably possible to submit the Claim in that time; and

(2) the Claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the Claim.

The Plan or its designee will determine if enough information has been submitted to enable proper consideration of the Claim. If not, more information may be requested from the Claimant.

Non-Preferred Provider Claims—Claims should be filed within 365 days of the date the expenses for the services were incurred. Benefits are based on the Plan's provisions at the time the expenses were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the Claim in that time (i.e., the person is not legally capable of submitting the Claim).

The Plan or its designee will determine if enough information has been submitted to enable proper consideration of the Claim. If not, more information may be requested from the Claimant.

CLAIMS REVIEW PROCEDURE

A request for Plan benefits will be considered a Claim for Plan benefits, and it will be subject to a full and fair review. This means that Claims will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. If a Claim is wholly or partially denied, or if coverage is rescinded retroactively for fraud or misrepresentation of a material fact, the Plan or its designee will furnish the Claimant with a written notice of this Adverse Benefit Determination, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. The notice will be stated in a manner calculated to be understood by the Claimant and will contain the following information:

(1) Information sufficient to allow the Claimant to identify the Claim involved including the date of service; the healthcare Provider; the Claim amount (if applicable);

(2) A statement that the diagnosis code and its corresponding meaning; and the treatment code and its corresponding meaning will be provided free of charge upon request;

(3) The specific reason or reasons for the Adverse Benefit Determination;

(4) Reference to the specific Plan provisions on which the determination was based;

(5) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;

(6) A description of the Plan's internal appeals and external review procedures, and the time limits applicable to such procedures;

(7) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to,

and copies of, all documents, records and other information relevant to the Claim;

(8) The statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

(9) Any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

(10) If the Adverse Benefit Determination is based on Medical Necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request;

(11) Information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeal and external review process.

Urgent Care Claims
Upon receipt of a Preauthorization request for urgent care, the Plan or its designee will notify the Claimant of the benefit determination as soon as possible, but not later than 72 hours. If sufficient information was not provided to determine benefits payable under the Plan, the Plan or its designee will notify the Claimant within 24 hours of receipt of the request. The Claimant will be provided a reasonable amount of time, but not less than 48 hours to provide the specified information. The Claim will be denied if the requested information is not received within the time frame given to provide the information. The Plan or its designee will notify the Claimant of the benefit determination within 48 hours after receipt of the requested information. If the notification is provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.

If there is an Adverse Benefit Determination on a Preauthorization request involving Urgent Care where the time for completion of an internal appeal would seriously jeopardize the Claimant's life, health or ability to regain maximum function, the Claimant, his or her Physician or other healthcare Provider may request an expedited internal appeal. An expedited external review by an independent review organization may be requested at the same time the Claimant, his or her Physician or other healthcare Provider requests an expedited internal appeal, if he or she believes that the time frame for completion of an expedited internal appeal would seriously jeopardize the Claimant's life, health or ability to regain maximum function. The request for an expedited internal appeal and/or an expedited external review may be submitted orally or in writing by the Claimant (see the "CLAIMS DENIAL APPEAL PROCEDURE—EXTERNAL REVIEW OF APPEALS, Expedited Medical Necessity Review" section).

If the request is denied due to treatment being experimental or investigational and the Claimant's Physician certifies in writing that treatment would be significantly less effective if not promptly initiated, the Claimant may request an expedited external review of the denial at the same time he/she requests an expedited internal appeal of the denial.

All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile or other similarly expeditious method.

Pre-Service Claims
Upon receipt of a Preauthorization request, the Plan or its designee will notify the Claimant of the benefit determination as soon as possible but not later than 15 days from the date of receipt of the request for Preauthorization. If sufficient information was not provided to determine benefits payable under the Plan, the Plan or its designee will notify the Claimant of the specific information needed within three days of the receipt of the request for Preauthorization. The Claimant will have 45 days from the date of receipt of the notice to provide the requested information. The Plan or its designee will notify the Claimant of the benefit determination within 15 days after receipt of the requested information or within 15 days after the end of the time frame given to provide the additional information, whichever is earlier.

The Plan or its designee will notify the Claimant within 15 days from the date of receipt of the request for Preauthorization if special circumstances require an extension of time for determining benefits. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render a

decision. In no event will the extension exceed a period of 15 days from the end of the initial 15-day period.

If the Preauthorization request is denied, the Claimant may request an appeal of the denial (see the "CLAIMS DENIAL APPEAL PROCEDURE" section). If the Preauthorization request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and the Claimant has exhausted the internal appeals process, he/she also has the right to request that the decision be reviewed by an independent review organization (see the "CLAIMS DENIAL APPEAL PROCEDURE—EXTERNAL REVIEW OF APPEALS" section).

Post-Service Claims
A Post-Service Claim will be deemed to be filed on the date that Third Party Administrator receives a Claim. The Plan or its designee will notify the Claimant of the Plan's benefit determination within a reasonable period of time, but not later than 30 days from the date of receipt of the Claim. If sufficient information was not provided to determine benefits payable under the Plan, the Plan or its designee will notify the Claimant of the specific information needed within 30 days of the receipt of the Claim. The Claimant will have 45 days from the date of receipt of the notice to provide the requested information. The Plan or its designee will notify the Claimant of the benefit determination within 15 days after receipt of the requested information or within 15 days of after the end of the time frame given to provide the additional information, whichever is earlier.

The Plan or its designee will notify the Claimant within the 30-day period if special circumstances require an extension of time for determining benefits. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render a decision. In no event will the extension exceed a period of 15 days from the end of the initial 30-day period.

If the Preauthorization request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and the Claimant has exhausted the internal appeals process, he/she also has the right to request that the decision be reviewed by an independent review organization (see the "CLAIMS DENIAL APPEAL PROCEDURE—EXTERNAL REVIEW OF APPEALS" section).

Concurrent Care Claims
Any reduction or termination by the Plan of concurrent care (other than by Plan Amendment or termination) before the end of an approved period of time or number of treatments will constitute an Adverse Benefit Determination. The Plan or its designee will notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated (see the "CLAIMS DENIAL APPEAL PROCEDURE—MEDICAL NECESSITY REVIEW, Concurrent Care Claims" section).

If there is an Adverse Benefit Determination on a Preauthorization request involving concurrent care where the time frame for completion of an internal appeal would seriously jeopardize the Claimant's life, health or ability to regain maximum function, the Claimant, his/her Physician or other healthcare Provider may request an expedited internal appeal. If the Claimant, Physician or other healthcare Provider believes that the time frame for an expedited internal appeal would jeopardize the Claimant's life, health or ability to regain maximum function, he/she has the right to request an expedited external review at the same time of the request for an expedited internal review. The request for an expedited internal/external appeal may be submitted orally or in writing by the Claimant (see the "CLAIMS DENIAL APPEAL PROCEDURE—EXTERNAL REVIEW OF APPEALS, Expedited Medical Necessity Review" section).

If the denial of coverage is based on the determination that the requested treatment is experimental or investigational and the Claimant's healthcare Provider certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, he/she may request an expedited external review by an independent review organization (see the "CLAIMS DENIAL APPEAL PROCEDURE—EXTERNAL REVIEW OF APPEALS, Expedited Medical Necessity Review" section).

Rescission of Coverage
A Rescission of coverage for fraud or misrepresentation of a material fact will constitute an Adverse Benefit Determination. The Plan or its designee will provide the Claimant at least 30-days' advance-written notice of such action to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination.

CLAIMS DENIAL APPEAL PROCEDURE

Appeals are divided into two categories: administrative decisions or denials of coverage based on Medical Necessity. A Claimant may submit written comments, documents, records and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. A document, record or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

A review committee or an individual not involved in the initial Adverse Benefit Determination and who does not work under the authority of the initial decision maker will review administrative appeals.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a Healthcare Professional who was not involved in the original benefit determination. This Healthcare Professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

ADMINISTRATIVE REVIEW

In cases where a Claim is wholly or partially denied on the basis of an administrative decision, the Claimant may request an appeal of the Adverse Benefit Determination by calling or writing the "Adverse Benefit Determination Review Facilitator for Administrative Reviews (First Appeal Level)" listed in the "GENERAL PLAN INFORMATION" section of this document. The request for a first appeal must be made within 180 days (or 30 days for Rescission of coverage) after the Claimant receives notification of the Adverse Benefit Determination.

Post-Service Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim. Within three business days, the Plan or its designee will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician and/or other healthcare Provider a written notice of the decision within 15 days of receipt of all requested information.

Second Appeal—If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Administrative Reviews (Second Appeal Level)" listed in the "GENERAL PLAN INFORMATION" section of this document within 60 days of the receipt of the Adverse Benefit Determination.

The Plan's committee or board will review the appeal no later than the date of the next meeting of the committee or board that immediately follows the Plan's receipt of the appeal, unless the appeal is filed within 30 days preceding the

date of such meeting. In such case, a decision will be made by no later than the date of the second meeting following the Plan's receipt of the appeal.

If special circumstances (such as the need to hold a hearing or the need for additional information to evaluate the appeal) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Plan Administrator/Plan Sponsor shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Plan Administrator/Plan Sponsor shall notify the Claimant of the decision as soon as possible, but not later than five days after the decision is made.

Pre-Service Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim. Within three business days, the Plan or its designee will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician or other healthcare Provider who recommended services a written notice of the decision within 15 days of the receipt of all requested information.

Second Appeal—If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Administrative Reviews (Second Appeal Level)" listed in the "GENERAL PLAN INFORMATION" section of this document within 60 days of the receipt of the Adverse Benefit Determination. The Plan or its designee will review the Claim within three business days and will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician and/or other healthcare Provider a written notice of the decision within 15 days of receipt of all requested information.

Urgent Care Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and notify the Claimant of the decision no later than 72 hours after receipt of the request.

Second Appeal—If the Plan denies the Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Administrative Reviews (Second Appeal Level)" listed in the "GENERAL PLAN INFORMATION" section of this document. Both the first and second appeals will be completed as soon as possible, taking into account the medical exigencies, but not longer than 72 hours. The Claimant or his/her authorized representative will be notified by telephone as soon as the decision is made and in writing within three days of the decision.

Rescission of Coverage
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim. Within three business days, the Plan or its designee will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician or other healthcare Provider who recommended services a written notice of the decision within 15 days of the receipt of all requested information.

Second Appeal—If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Administrative Reviews (Second Appeal Level)" listed in the "GENERAL PLAN INFORMATION" section of this document within 60 days of the receipt of the Adverse Benefit Determination. The Plan or its designee will review the Claim within three business days and will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician and/or other healthcare Provider a written notice of the decision within 15 days of receipt of all requested information.

If the appeal request is denied on the basis of an administrative decision, and the Claimant has exhausted the internal appeals process, he/she has the right to request that decision be reviewed by an independent review organization (see the subsection "EXTERNAL REVIEW OF APPEALS").

MEDICAL NECESSITY REVIEW

In cases where a Claim is wholly or partially denied based on Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, the Claimant may request an appeal of the Adverse Benefit Determination by calling or writing the "Adverse Benefit Determination Review Facilitator for Medical Necessity Reviews" listed in the "GENERAL PLAN INFORMATION" section of this document. The request for review must be directed to the "Adverse Benefit Determination Review Facilitator for Medical Necessity Reviews" within 180 days after receiving notification of the Adverse Benefit Determination.

The Plan or its designee shall provide the Claimant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge as soon as possible, and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant to respond.

Post-Service Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim. Within three business days, the Plan or its designee will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician or other healthcare Provider a written notice of the Plan's decision within 15 days of receipt of all requested information.

Second Appeal—If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Medical Necessity Reviews" listed in the "GENERAL PLAN INFORMATION" section of this document within 60 days of the receipt of the Adverse Benefit Determination.

The Plan's committee or board will review the appeal no later than the date of the next meeting of the committee or board that immediately follows the Plan's receipt of the appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, a decision will be made by no later than the date of the second meeting following the Plan's receipt of the appeal.

If special circumstances (such as the need to hold a hearing or the need for additional information to evaluate the appeal) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Plan Administrator/Plan Sponsor shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Plan Administrator/Plan Sponsor shall notify the Claimant of the decision as soon as possible, but not later than five days after the decision is made.

If the Claim for coverage is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and the Claimant has exhausted the internal appeals process, he/she has the right to request that decision be reviewed by an independent review organization (see the subsection "EXTERNAL REVIEW OF APPEALS").

Pre-Service Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim. Within three business days, the Plan or its designee will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician or other healthcare Provider who recommended services a written notice of the decision within 15 days of the receipt of all requested information.

Second Appeal—If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Medical Necessity Reviews" listed in the "GENERAL PLAN INFORMATION" section of this document within 60 days of the receipt of the Adverse Benefit Determination. The Plan or its designee will review the Claim within three business days and will advise the party requesting the appeal of all information required to evaluate the appeal. The Plan or its designee will provide the Claimant, his/her authorized representative, Physician and/or other healthcare Provider a written notice of the decision within 15 days of receipt of all requested information.

If the appeal request is denied on the basis of Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness, and the Claimant has exhausted the internal appeals process, he/she has the right to request that decision be reviewed by an independent review organization (see the subsection "EXTERNAL REVIEW OF APPEALS").

Urgent Care Claims
First Appeal—Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and notify the Claimant of the decision no later than 72 hours after receipt of the request.

Second Appeal—If the Plan denies the Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the "Adverse Benefit Determination Review Facilitator for Medical Necessity Reviews" listed in the "GENERAL PLAN INFORMATION" section of this document. Both the first and second appeals will be completed as soon as possible, taking into account the medical exigencies, but not longer than 72 hours. The Claimant or his/her authorized representative will be notified by telephone as soon as the decision is made and in writing within three days of the decision.

If there is an Adverse Benefit Determination on a Claim involving urgent care where the time for completion of a standard appeal would seriously jeopardize the Claimant's life or the Claimant's ability to regain maximum function, the Claimant may request an expedited external review. The request for an expedited external review may be submitted orally or in writing by the Claimant or his/her authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile or other similarly expeditious method (see the subsection "EXTERNAL REVIEW OF APPEALS—Expedited External Review"), if:

(1) the Claimant, his/her Physician or other healthcare Provider believes that the time frame for completion of an external review would seriously jeopardize the Claimant's life, health or ability to regain maximum function;

(2) the Adverse Benefit Determination concerns an emergency admission, availability of care, continued stay and the Claimant has not been discharged from the facility or an ongoing treatment; or

(3) the Adverse Benefit Determination is based on the determination that the requested service or treatment is experimental or investigational and the healthcare Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated.

If the appeal request is denied and the Claimant has exhausted the internal appeals process, he/she has the right to request that decision be reviewed by an independent review organization (see the subsection "EXTERNAL REVIEW OF APPEALS").

Concurrent Care Claims
Appeals to extend concurrent care will be made in accordance with the Urgent Care Claims, Pre-Service Claims or Post-Service Claims procedures discussed above.

NOTICE OF APPEAL DETERMINATION

The Plan or its designee will furnish the Claimant with a written or electronic notice of a benefit determination on review at each level, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. The notice will be stated in a manner calculated to be understood by the Claimant. This written notice will contain the following information:

(1) Information sufficient to allow the Claimant to identify the Claim involved (including date of service; the healthcare Provider; the Claim amount, if applicable);

(2) A statement that the diagnosis code and its corresponding meaning; and the treatment code and its corresponding meaning, will be provided free of charge upon request;

(3) The specific reason or reasons for the Adverse Benefit Determination and the statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or state insurance regulatory agency;"

(4) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(5) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of any relevant document;

(6) A statement describing the Plan's internal appeals and external review procedures and the time limits applicable to such procedures;

(7) Any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

(8) If the Adverse Benefit Decision is based on whether the treatment or service is Medically Necessary or experimental or investigational, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified; and

(9) Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW OF APPEALS

If a Claimant receives a Final Adverse Benefit Determination under the Plan's internal claims and appeals procedures based on medical judgment or a Rescission of coverage, or if the Plan does not follow the appeal procedures properly (except for failures that are based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant), he or she may request that the Claim be reviewed under the Plan's external review process. The Claimant may request an external review by writing to the "External Review Facilitator" listed in the "GENERAL PLAN INFORMATION" section of this document. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The following provisions apply:

(1) The Plan waives any right to claim that the Claimant failed to exhaust administrative remedies because the Claimant did not submit a request for an external review.

(2) Any statute of limitation or other defense based on timeliness is pended during the time of the external review.

(3) Upon request, the Plan or its designee will provide the Claimant the information necessary to make an informed judgment about requesting an external review.

(4) The Claimant will not be responsible for paying any fees associated with an external review.

(5) If an appeal is denied, the written response to the Claimant will cite the specific Plan provision(s) upon which the Adverse Benefit Determination is based.

The Plan or its designee will determine whether the Claim is eligible for review under the external review process. This determination is based on whether:

(1) the Claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) the Adverse Benefit Determination relates to the Claimant's failure to meet the Plan's eligibility requirements;

(3) the Claimant has exhausted the Plan's internal claims and appeal procedures (a Claimant may request an expedited external review under certain circumstances [see the subsection "Expedited External Review"]); and

(4) the Claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Plan or its designee will provide written notification to the Claimant of whether the Claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Plan or its designee will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (1-866-444-3272).

If the request for review is not complete, the notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request for review is eligible for the external review process, the Plan or its designee will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its Adverse Benefit Determination. If the Adverse Benefit Determination is reversed, the external review process will end.

If the Plan does not reverse the Adverse Benefit Determination, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) the Claimant's medical records;

(2) the attending Healthcare Professional's recommendation;

(3) reports from appropriate Healthcare Professionals and other documents submitted by the plan or issuer, Claimant or the Claimant's treating Provider;

(4) the terms of the Plan;

(5) appropriate practice guidelines;

(6) any applicable clinical review criteria developed and used by the Plan; and

(7) the opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

(1) a general description of the reason for the external review, including information sufficient to identify the Claim;

(2) the date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) references to the evidence or documentation the IRO considered in reaching its decision;

(4) a discussion of the principal reason(s) for the IRO's decision;

(5) a statement that the determination is binding and that judicial review may be available to the Claimant; and

(6) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Expedited External Review. Generally, a Claimant must exhaust the Plan's claims and appeal procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

(1) the Claimant receives an Adverse Benefit Determination on a Claim that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures (i) would seriously jeopardize the Claimant's life or health or ability to regain maximum function; (ii) concerns an emergency

admission, availability of care, continued stay and the Claimant has not been discharged from the facility or an ongoing treatment; or (iii) is based on the determination that the requested service or treatment is experimental or investigational and the healthcare Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated.

(2) the Claimant receives a Final Adverse Benefit Determination on an appeal that involves a medical condition where the time for completion of a standard external review process (i) would seriously jeopardize the Claimant's life or health or ability to regain maximum function; (ii) concerns an emergency admission, availability of care, continued stay and the Claimant has not been discharged from the facility or an ongoing treatment; or (iii) is based on the determination that the requested service or treatment is experimental or investigational and the healthcare Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated.

Immediately upon receipt of a request for expedited external review, the Plan or its designee must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

DEFINITIONS FOR PURPOSES OF CLAIMS AND APPEALS

"Adverse Benefit Determination" means a denial, reduction, Rescission or termination of, or a failure to provide or make payment, in whole or in part, for a benefit. This includes any such determination based on an Employee's or Dependent's eligibility to participate in the Plan or resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to not be Medically Necessary.

"Claim" means a request for benefits under the Plan made by a Claimant in accordance with the Plan's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.

"Claimant" means a Covered Person or his or her authorized representative (including his or her Physician, attorney or other healthcare Provider) that complies with the Plan's reasonable procedure for making benefit Claims. If the Claim is an Urgent Care Claim, a Healthcare Professional with knowledge of the Covered Person's medical condition will be permitted to act as the Covered Person's representative.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the Plan's internal appeals procedure or an Adverse Benefit Determination for which the Plan's internal appeals procedures were not properly followed.

"Healthcare Professional" means a Physician or other healthcare professional licensed, accredited or certified to perform specified health services consistent with state law.

"Plan" means the written document used to communicate benefit provisions, limitations, rights, and obligations to persons covered under the Plan provided by the Plan Administrator/Plan Sponsor.

"Post-Service Claim" means any Claim for a Plan benefit that is not a Claim involving urgent care, concurrent care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for eligible medical services already received by the Claimant.

"Pre-Service Claim" means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Preauthorization.

"Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if:

- the cancellation or discontinuance has only a prospective effect; or

- the cancellation or discontinuance is effective retroactively to the extent it is attributable to a failure to timely pay required contributions toward the cost of coverage.

"Urgent Care Claim" means any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or in the opinion of the attending or consulting Physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving urgent care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

FILING A SUIT FOR BENEFITS

A Claimant must exhaust the internal Claims appeal procedure before filing a suit for benefits. In the event the Plan fails to properly follow its internal claims appeal procedures (except for failures that are based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant), the claims appeal procedures will be deemed exhausted. Any legal action for the recovery of any benefits must be commenced within 90 days after the Plan's claim review procedures have been exhausted.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Eligible Expenses when two or more plans—including Medicare—are paying. When an Employee is covered by this Plan and another plan, or the Employee's Spouse or Domestic Partner is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula less whatever the primary plan paid. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan—50 percent or 80 percent or 100 percent—whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical and prescription drug benefits of a benefit plan. For purposes of this "COORDINATION OF BENEFITS" section, the term "Benefit Plan" means this Plan or any one of the following plans:

(1) Group and nongroup insurance contracts and subscriber contracts.

(2) Uninsured arrangements of group and nongroup coverage.

(3) Group and nongroup coverage through closed panel plans.

(4) Group type contracts.

(5) Medical care component of long term care contracts such as skilled nursing care.

(6) Medical benefits coverage of "no-fault automobile insurance." For purposes of this subsection, "no-fault automobile insurance" means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

(7) Traditional automobile "fault" type contracts.

(8) Medicare, as permitted by law.

The term "Benefit Plan" does not include the following: hospital indemnity coverage benefits or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; or a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Allowable Expense. In order for an expense to be allowable for coordination of benefits, it must be considered an Eligible Expense under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans, this Plan will not consider any expenses incurred in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Expense any expense incurred that would have been paid by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service-type plans where services are provided as benefits, the reasonable cash value of each service will be considered the Allowable Expense.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Expense:

(a) **Non-dependent/Dependent.** The benefits of a Benefit Plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) **Active/Inactive employee.** The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers that person as a laid-off or retired employee. The benefits of a Benefit Plan which covers a person as a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers a person as a dependent of a laid-off or retired employee. If the other Benefit Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) **COBRA continuation coverage.** The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers the person as a COBRA beneficiary.

(d) **Dependent child/Parents not Legally-Separated or divorced.** When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the Benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the Benefit Plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the Benefit Plan which has covered the parent for the longer time are determined before those of the Benefit Plan which covers the other parent.

(e) **Dependent child/Parent Legally-Separated or divorced.** When a child's parents are divorced or Legally Separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The Benefit Plan of the parent with custody will be considered before the Benefit Plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The Benefit Plan of the parent with custody will be considered first. The Benefit Plan of the stepparent that provides benefits to the child as a dependent will be considered next. The Benefit Plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the Benefit Plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) **Dependent child/Joint custody.** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans providing benefits to the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) **Married adult Dependent child.** If a married adult Dependent child has his or her own coverage as a dependent under his or her spouse's plan and has coverage as a Dependent under either or both parent's plan, the plans covering the adult dependent child will follow the order of benefit determination rules outlined in (g) below.

(i) In the event that the adult Dependent child's coverage under his or her spouse's plan began on the same date as the adult Dependent child's coverage under either or both parent's plans, the plans covering the adult Dependent child will follow the order of benefit determination rules outlined in (d) above.

(g) **Longer/Shorter length of coverage:** If there is still a conflict after these rules have been applied, the benefit plan which has covered the person for the longer time will be considered first. When there is a conflict in the coordination of benefit rules, the Plan will never pay more than 50 percent of Allowable Expenses when paying secondary.

(3) **Medicare.** Medicare will pay primary, secondary or last to the extent required by federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through the Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

The Plan elects treatment under 42 USC 1395y(b)(1)(A)(iii).

(4) If a Covered Person is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. Each Covered Person claiming benefits under this Plan must provide the Plan the information it asks for about other plans and their payment of Allowable Expenses.

The Plan may also request updated information from the Covered Person annually, or when information is received that indicates a change from the information the Plan has on file, to verify or update his or her coordination of benefits information. If no response is received within 45 days from the Covered Person's receipt of the request of information, the Covered Person's claim(s) will be denied.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another Benefit Plan. In this case, this Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Expense. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical expenses due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100 percent, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical expenses, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible Third Party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the Covered Person's Third Party claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical expenses as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Benefits. The Plan shall have no obligation whatsoever to pay a Covered Person's medical expenses if the Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical expenses incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his/her authorized legal representative obtains valid court recognition and approval of the Plan's 100 percent, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator/Plan Sponsor. The Plan Administrator/Plan Sponsor has a right to request reports on and approve of all settlements.

DEFINITIONS FOR PURPOSES OF THIRD-PARTY RECOVERY

"Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical expenses that are eligible under the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefit expenses that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical expenses against the other person.

"Third Party" means any Third Party including another person or a business entity.

MEDICARE-ELIGIBLE BENEFICIARIES

The federal "Medicare Secondary Payer" (MSP) laws regulate how certain employers may offer group health plan benefits to Medicare-Eligible Employees and Dependents ("Beneficiaries").

Under the MSP laws, Medicare generally pays secondary to the benefits provided by the Plan. Following are some common situations when Medicare would be the secondary payer for a Medicare-Eligible Beneficiary:

- A Beneficiary with end-stage renal disease who is covered under the Plan, during the first 30 months of his or her Medicare eligibility or entitlement;

- A Beneficiary age 65 and older who is covered under the Plan due to their or their Spouse's or Domestic Partner's current employment status with the Employer, 'if the Employer has 20 or more Employees;

- A disabled Beneficiary under age 65 who is covered under the Plan due to their or a family member's current employment status (i.e., while you are actively at work or for the first six months that you receive disability benefits) with the Employer, if the Employer employs more than 100 Employees.

To assist the Employer and the Plan in complying with the MSP laws, an Employee must notify the Employer promptly if he or she or any of his or her covered Dependents become eligible for Medicare or have Medicare eligibility terminated or changed. An Employee must also promptly and accurately complete any requests for information from the Employer concerning his or her or any covered Dependents' Medicare eligibility.

Medicare is the primary coverage for those Medicare-Eligible Beneficiaries to whom the MSP laws do not apply (for example, who are age 65 or older). The benefits of the Plan for such Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available for such services or items if the Beneficiary enrolled in Medicare and made a proper claim for Medicare payment. (See "Medicare Benefits" under the "PLAN EXCLUSIONS" section for this exclusion and the "DEFINED TERMS" section for the definition of "Medicare-Eligible Beneficiary.")

To obtain the greatest benefits available under the Plan, a Medicare-Eligible Beneficiary to whom the MSP laws do not apply should:

- enroll in Part A, Part B and Part D of Medicare.

- assign his or her claim for Medicare benefits to the Provider.

- obtain needed healthcare services and items from Preferred Providers according to the terms and conditions of the Plan.

  For services received from a Preferred Provider, the Plan will consider eligible any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section for which Medicare does not pay, except copayments or coinsurance for Prescription Drugs.

  For services received from Non-Preferred Providers, Covered Persons who have Medicare Part A and Part B as primary coverage are responsible for Plan copayments, coinsurance, and out-of-pocket maximums prior to the Plan considering eligible any applicable Medicare deductibles or coinsurance.

If a Covered Person does not enroll in Part B of Medicare, he or she will be responsible for the portion of the bills that Medicare would have allowed under Part B coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain individuals covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform those individuals, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the U.S. Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage for this Plan is administered by the COBRA Administrator listed in the "GENERAL PLAN INFORMATION" section of this document. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to individuals who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace ("Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. See the subsection "Are there other coverage options available besides COBRA continuation coverage?" below for additional information.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain individuals who lose coverage (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of an event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary is considered to be any of the following:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States of America. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

However, the Plan will treat a Civil Union partner or Domestic Partner and his or her children as Qualified Beneficiaries

if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this “”section, the Civil Union partner or Domestic Partner will be treated as the Spouse of the Employee and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Civil Union partner or Domestic Partner ceases to be met. This gives the Civil Union partner or Domestic Partner and his or her children the contractual rights outlined in this section but does not extend statutory remedies to the Civil Union partner or Domestic Partner or child.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? Qualifying Events are certain events that would cause an individual to lose their health coverage under the Plan. The type of Qualifying Event determines who the Qualified Beneficiaries are and the amount of time that the Plan must offer COBRA continuation coverage to them. A Qualifying Event is considered any of the following if the Plan Administrator/Plan Sponsor provided that the individual would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.

(3) The divorce or Legal Separation of a covered Employee from the Employee’s Spouse. If the Employee reduces or eliminates the Employee’s Spouse’s Plan coverage in anticipation of a divorce or Legal Separation, and a divorce or Legal Separation later occurs, then the divorce or Legal Separation may be considered a Qualifying Event even though the Spouse’s coverage was reduced or eliminated before the divorce or Legal Separation.

(4) A covered Employee’s enrollment in any part of the Medicare program.

(5) A covered Dependent child’s ceasing to satisfy the Plan’s requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (“FMLA”) does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for healthcare coverage, Qualified Beneficiaries should consider the following:

- **Coverage premiums.** This Plan can charge up to 102 percent of total Plan premiums for COBRA continuation coverage. Other options, like coverage through a Spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). Qualified Beneficiaries have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider networks.** If a Qualified Beneficiary is currently receiving care or treatment for a condition, a change in healthcare coverage may affect access to a particular healthcare Provider. You may want to check to see if your current healthcare Providers participate in a network when considering other healthcare coverage options.

- **Drug formularies.** For Qualified Beneficiaries taking medication, a change in healthcare coverage may affect costs for medication and, in some cases, the medication may not be considered an eligible expense under another plan. Qualified Beneficiaries should check to see if their current medications are listed in drug formularies for other healthcare coverage.

- **Severance payments.** If COBRA rights arise because the Employee has lost his or her job and there is a severance package available from the Employer, the former Employer may have offered to pay some or all of the Employee's COBRA continuation coverage premium payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the U.S. Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare eligibility.** A Qualified Beneficiary should be aware of how COBRA continuation coverage coordinates with Medicare eligibility. If a Qualified Beneficiary is eligible for Medicare at the time of the Qualifying Event, or if the Qualified Beneficiary will become eligible soon after the Qualifying Event, the Qualified Beneficiary should be aware that he or she has eight months to enroll in Medicare after his or her employment-related health coverage ends. Electing COBRA continuation coverage does not extend this eight-month period. For more information, visit medicare.gov/sign-up-change-plan.

- **Service areas.** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the service or coverage area.

- **Other cost sharing requirements.** In addition to premiums or contributions for healthcare coverage, the Plan requires individuals to pay deductibles, copayments, coinsurance or other amounts as benefits are used. Qualified Beneficiaries should check to see what the cost sharing requirements are for other healthcare coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options available besides COBRA continuation coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or another group health plan (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Qualified Beneficiaries can learn more about many of these options by visiting www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is considered timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA continuation coverage within the normal election period, a second opportunity to elect COBRA

continuation coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator/Plan Sponsor for further information. If COBRA continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator/Plan Sponsor of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator/Plan Sponsor or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator/Plan Sponsor) will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is any of the following:

(1) The end of employment or reduction of hours of employment,

(2) Death of the Employee,

(3) Commencement of a proceeding in bankruptcy with respect to the Employer, or

(4) Entitlement of the Employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or Legal Separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator/Plan Sponsor or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator/Plan Sponsor or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage. You must send this notice to the Plan Administrator/Plan Sponsor or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator/Plan Sponsor or its designee as specified in the "GENERAL PLAN INFORMATION" section of this document.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include the following:

- The **name of the Plan or Plans** under which you lost or are losing coverage;
- The **name and address of the Employee** covered under the Plan;
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**; and
- The **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or Legal Separation**, your notice must include **a copy of the divorce decree or the Legal Separation agreement.**

Be aware that there are other notice requirements in other contexts (for example, in order to qualify for a disability extension).

Once the Plan Administrator/Plan Sponsor or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator listed in the "GENERAL PLAN INFORMATION" section of this document. Each Qualified Beneficiary will have an independent right to elect

COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If COBRA continuation coverage is not elected within the 60-day election period described above, the right to elect COBRA continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator/Plan Sponsor or its designee, as applicable.

Is COBRA continuation coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. However, a Qualified Beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either Part A or Part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate the COBRA continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan terminates the coverage of similarly situated non-COBRA beneficiaries for cause, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as described below:

(1) In the case of a Qualifying Event that is a covered Employee's termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator/Plan Sponsor must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must also be sent to the COBRA Administrator in accordance with the notice procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator/Plan Sponsor with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must also be sent to the COBRA Administrator in accordance with the notice procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102 percent of the applicable premium and up to 150 percent of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? For purposes of this "CONTINUATION OF COVERAGE RIGHTS UNDER COBRA" section, "Timely Payment" means a payment made no later than 30 days after the first day of the COBRA continuation coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their COBRA continuation coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of COBRA continuation coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" means 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10 percent of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/agencies/ebsa.

KEEP THE PLAN ADMINISTRATOR/PLAN SPONSOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator/Plan Sponsor informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator/Plan Sponsor.

ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF) BENEFITS

In all cases, a covered Employee can choose between COBRA continuation coverage or continuing coverage under the terms of the Plan as an IMRF Participant, if the IMRF Participant satisfies the criteria specified in this section.

If the covered Employee is eligible and chooses to continue coverage under the terms of the Plan as an IMRF Participant, he or she will waive his or her right to elect COBRA continuation coverage at a later date.

NOTE: Any continuance period provided pursuant to this section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the "CONTINUATION COVERAGE RIGHTS UNDER COBRA" section.

The following individuals will have the right to continue coverage at their own expense when an Employee's eligibility under this Plan ends:

(1) a full-time, Active Employee who is removed from the Employer's payroll due to retirement or disability, and who immediately becomes entitled to receive an IMRF pension or disability benefit;

(2) the covered Dependents of such an IMRF Participant who are covered under the Plan on the day before such Employee is removed from the Employer's payroll; and

(3) the surviving Spouse/Domestic Partner of such an IMRF Participant, but only if the Spouse/Domestic Partner:

- **(a)** is covered under the Plan on the day before such Employee's death;
- **(b)** is eligible for IMRF benefits and elects to receive a surviving Spouse/Domestic Partner pension (rather than a lump sum death benefit).

Coverage under this section may be continued until the earliest of:

(1) the date the IMRF Participant:

- **(a)** again becomes an active participant in IMRF or, if not covered by IMRF;
- **(b)** commences work as a full-time, Active Employee with the Employer or another entity;
- **(c)** is convicted of an IMRF job-related felony;
- **(d)** dies; or
- **(e)** fails to pay any required contribution for coverage.

(2) the date an IMRF Participant is no longer entitled to IMRF benefit payments or takes a separation refund;

(3) the date a Spouse/Domestic Partner or child ceases to be an eligible Dependent under the terms of the Plan;

(4) the date the surviving Spouse/Domestic Partner:

- **(a)** remarries prior to age 55;
- **(b)** dies; or
- **(c)** fails to pay any required contribution for coverage;

(5) the date the Employer terminates medical coverage for all Employees; or

(6) If an IMRF Participant, surviving Spouse/Domestic Partner and/or his or her covered Dependent child(ren) commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator/Plan Sponsor that he or she has become ineligible for coverage, then the Employer or Plan Administrator/Plan Sponsor may

either void coverage for the IMRF Participant, surviving Spouse/Domestic Partner and covered Dependent child(ren) for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's/Plan Sponsor's discretion, may rescind coverage or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30-days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the IMRF Participant's and/or Dependent's paid contributions.

Coverage for such IMRF Participants and surviving Spouses/Domestic Partners will be the same as for other Covered Persons and will be subject to any benefit changes or cost increases which take effect after the Employee is removed from the Employer's payroll. The IMRF Participant or surviving Spouse/Domestic Partner will be required to pay 100 percent of the cost of Plan coverage by each monthly due date.

Within 15 days after a full-time, Active Employee retires, is removed from the Employer's payroll due to disability, or dies, the Employer will:

(1) verify the Employee's or surviving Spouse's/Domestic Partner's eligibility for IMRF or other pension benefits; and

(2) send the Employee or surviving Spouse/Domestic Partner a notice of this continuation privilege (including the cost for continued coverage under the Plan).

For a disabled IMRF Participant, this continuation right will apply only if, after reviewing his or her medical information, the IMRF determines that IMRF disability benefits are payable. For a surviving Spouse/Domestic Partner of a disabled IMRF Participant, this continuation right will apply only if the Spouse/Domestic Partner elects a monthly annuity (rather than a lump sum death benefit).

To continue coverage under the Plan, the IMRF Participant or surviving Spouse/Domestic Partner must send the Employer written election and first payment within 31 days after receipt of notice. In some cases, the individual may sign written authorization for IMRF to deduct future monthly payments for the cost of Plan coverage from his or her recurring IMRF benefit payments.

GENERAL PLAN ADMINISTRATION INFORMATION

RESPONSIBILITIES FOR PLAN ADMINISTRATION **Plan Administrator/Plan Sponsor.** Illinois Educators Risk Management Program Association, or such other party as designated from time to time by Illinois Educators Risk Management Program Association, is the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Illinois Educators Risk Management Program Association to be Plan Administrator/Plan Sponsor and to serve at the convenience and direction of the Employer. If the Plan Administrator/Plan Sponsor or a committee member resigns, dies or is otherwise removed from the position, Illinois Educators Risk Management Program Association shall appoint a new Plan Administrator/Plan Sponsor as soon as reasonably possible.

Illinois Educators Risk Management Program Group Health Plan is the benefit plan of Illinois Educators Risk Management Program Association. It is to be administered by the Plan Administrator/Plan Sponsor in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator/Plan Sponsor shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator/Plan Sponsor will be final and binding on all interested parties.

Duties of the Plan Administrator/Plan Sponsor. The Plan Administrator/Plan Sponsor will have the duties of the general administration of this Plan, including the following:

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes that may arise relative to a Covered Person's rights and/or availability of benefits.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Third Party Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

(8) To perform each and every function necessary for or related to the Plan's administration.

Plan Administrator/Plan Sponsor Compensation. The Plan Administrator/Plan Sponsor serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Third Party Administrator is not a Fiduciary. A Third Party Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator/Plan Sponsor.

Compliance with HIPAA Privacy Standards. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this "Compliance with HIPAA Privacy Standards" subsection is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's

administrative functions shall include all Plan payment and healthcare operations. The terms "payment" and "healthcare operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for healthcare. "Healthcare operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of Genetic Information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this "Compliance with HIPAA Privacy Standards" subsection, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.**(a)** **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including the following:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) make available Protected Health Information to individual Plan participants in accordance with Section 164.524 of the Privacy Standards;

(f) make available Protected Health Information for amendment by individual Plan participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) make available the Protected Health Information required to provide any accounting of disclosures to individual Plan participants in accordance with Section 164.528 of the Privacy Standards;

(h) make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Employer's workforce are designated as authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan: Plan Sponsor Board Members, Plan Sponsor Executive Board Members, Plan Sponsor Officers, Plan Administrator Officers.

Compliance with HIPAA Electronic Security Standards. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

Cost of the Plan Coverage, Funding the Plan and Payment of Benefits.

Cost of the Plan Coverage. The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment materials for Employee coverage include a payroll deduction authorization, which must be completed in a manner set forth by the Plan Administrator/Plan Sponsor.

IMRF Participants must pay the entire cost of IMRF Participants and Dependent coverage under this Plan. The IMRF Participants is responsible for making premium payments for IMRF Participants and Dependent coverage directly to the Employer by the due date specified by the Employer.

The required contribution amounts are set by the Plan Administrator/Plan Sponsor and a schedule of those amounts is distributed periodically to communicate the applicable contribution amounts. The Plan Administrator/Plan Sponsor reserves the right to change the level of required contributions.

Funding the Plan. The Plan is self-funded and the cost of the benefits provided under the Plan is funded as follows: Funding is derived from the funds of the Plan Administrator/Plan Sponsor and the Employer and contributions made by the enrolled Covered Persons.

The contributions made by the Employees and IMRF Participants will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee and IMRF Participants or withheld from the Employee's pay through payroll deduction.

Payment of Benefits. Benefits are paid directly from the Plan through the Third Party Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

ASSIGNMENT OF BENEFITS

Upon written authorization of the Covered Person (custodial parent or Legal Guardian if a minor), benefits under this Plan may be assigned to a Provider.

CLAIMS MISTAKENLY PAID

The Third Party Administrator, on behalf of the Plan, shall have the right to recover any payment which has been mistakenly paid on behalf of a Covered Person. A payment by the Third Party Administrator in accordance with the Plan is not an admission by the Plan or Third Party Administrator that the charges with respect to a claim for benefits are eligible for benefits under the Plan.

CLERICAL ERROR

Any clerical error by the Plan Administrator/Plan Sponsor or an agent of the Plan Administrator/Plan Sponsor in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

FACILITY OF PAYMENT

In the absence of a request for payment from a Legal Guardian or other legally-appointed representative, the Third Party Administrator may, at its option, make direct payment to the individual or institution appearing to have assumed custody of a Covered Person who is a minor or is not competent to give a valid receipt for payment of any benefit due him or her under the Plan.

If a Covered Person dies and benefits remain unpaid, the Third Party Administrator may, at its option, direct payments to the healthcare Provider rendering the service for which benefits are due, or to the Covered Person's surviving spouse, child(ren) share and share alike, or if none, to the executor(s) or administrator(s) of the Covered Person's estate. In the event any question or dispute shall arise as to the proper person or persons to whom any payment shall be made, the Plan Administrator/Plan Sponsor may direct the Third Party Administrator to withhold such payment until there shall have been made satisfactory adjudication of such question or dispute, or until the Plan Administrator/Plan Sponsor and the Third Party Administrator have been fully protected against loss by means of such indemnification, agreement or bond as it determines to be adequate.

RIGHT TO RECOVERY

If the total payments made by the Plan as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Plan shall have the right to recover the extra amount of such payments from

one or more of the following, as the Plan will determine: any person to, for or with respect to whom such payments were made, any other insurance companies, any other health plan, and any other organizations.

GENERAL PLAN INFORMATION This section provides details about the Plan, including pertinent addresses and telephone numbers relative to the administration of the Plan.

TYPE OF ADMINISTRATION

This Plan is a self-funded group health Plan and the administration is provided through a Third Party Administrator. The funding for the benefits is derived from the funds of the Trust and contributions made by covered Employees and covered IMRF Participants. The Plan is not insured.

PLAN NAME

Illinois Educators Risk Management Program Group Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 47-4631433

PLAN EFFECTIVE DATE: September 1, 2015

PLAN RESTATEMENT DATE: January 01, 2018

PLAN YEAR ENDS: August 31

TRUST

Trust is Illinois Educators Risk Management Program Trust, as described in the Illinois Educators Risk Management Program Association Intergovernmental Cooperation Agreement.

PLAN ADMINISTRATOR/PLAN SPONSOR

Illinois Educators Risk Management Program Association
c/o Loman-Ray Insurance Group, Inc.
P.O. Box 200
108 S. Lincoln St.
Broadlands, IL 61816
217-834-3309
Fax: 217-834-3300

AGENT FOR SERVICE OF LEGAL PROCESS

Illinois Educators Risk Management Program Association
c/o Loman-Ray Insurance Group, Inc.
P.O. Box 200
108 S. Lincoln St.
Broadlands, IL 61816
217-834-3309

THIRD PARTY ADMINISTRATOR

Through March 31, 2018:	Effective April 1, 2018:
Health Alliance Medical Plans, Inc.	Health Alliance Medical Plans, Inc.
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-322-7451	1-800-322-7451
HealthAlliance.org	HealthAlliance.org

UTILIZATION REVIEW MANAGER

Health Alliance Medical Plans, Inc.
1-800-322-7451

PHARMACY BENEFIT MANAGER

OptumRx	
Through March 31, 2018:	Effective April 1, 2018:
c/o Health Alliance Pharmacy Department	c/o Health Alliance Pharmacy Department
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-851-3379, extension 8078	1-800-851-3379, extension 8078
HealthAlliance.org	HealthAlliance.org

HEALTH SAVINGS ACCOUNT ADMINISTRATOR (Applicable to Covered Persons who have elected and are participating in the QHDHP option)

Benefit Planning Consultants (BPC)
2110 Clearlake Blvd., Ste. 200
P.O. Box 7500
Champaign, IL 61826-7500
217-355-2300
Fax: 217-255-5100

COBRA ADMINISTRATOR

Benefit Planning Consultants (BPC)
2110 Clearlake Blvd., Ste. 200
P.O. Box 7500
Champaign, IL 61826-7500
217-355-2300
Fax: 217-255-5100

ADVERSE BENEFIT DETERMINATION FACILITATOR FOR ADMINISTRATIVE REVIEWS (FIRST APPEAL LEVEL)

Through March 31, 2018:	Effective April 1, 2018:
Member Relations Department—Appeals	Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.	Health Alliance Medical Plans, Inc.
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-500-3373	1-800-500-3373
Fax: 217-337-8009	Fax: 217-902-9708

ADVERSE BENEFIT DETERMINATION FACILITATOR FOR ADMINISTRATIVE REVIEWS (SECOND APPEAL LEVEL)

Through March 31, 2018:	Effective April 1, 2018:
Member Relations Department—Appeals	Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.	Health Alliance Medical Plans, Inc.
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-500-3373	1-800-500-3373
Fax: 217-337-8009	Fax: 217-902-9708

ADVERSE BENEFIT DETERMINATION FACILITATOR FOR MEDICAL NECESSITY REVIEWS

Through March 31, 2018:	Effective April 1, 2018:
Member Relations Department—Appeals	Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.	Health Alliance Medical Plans, Inc.
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-500-3373	1-800-500-3373
Fax: 217-337-8009	Fax: 217-902-9708

EXTERNAL REVIEW FACILITATOR

Through March 31, 2018:	Effective April 1, 2018:
Member Relations Department—Appeals	Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.	Health Alliance Medical Plans, Inc.
301 S. Vine St.	3310 Fields South Drive
Urbana, IL 61801-3347	Champaign, IL 61822
1-800-500-3373	1-800-500-3373
Fax: 217-337-8009	Fax: 217-902-9708

EXHIBIT 1

BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS
EFFECTIVE 1/1/2018 THROUGH 4/30/2018

This "EXHIBIT 1" is to be used in conjunction with the "Preventive Care Services" and "Well-Child Care Services" subsections of the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section of this Plan. Covered Persons may also receive a hard copy of the information contained in this "EXHIBIT 1" section in a brochure-type format.

For questions related to this "EXHIBIT 1" section, contact the Third Party Administrator's Customer Service Department at the phone number listed in the "GENERAL PLAN INFORMATION" section of this document.

Following is a partial list of the services included in your comprehensive preventive care services benefit:*

- One preventive care exam per Covered Person (no age limitations) per Plan Year
- One preventive care visit to an OB/GYN Principal Healthcare Provider per year
- Well-child care
- The screenings, procedures and immunizations listed below, within the applicable preventive care services benefit:
  - Blood sugar screening
  - Cervical cancer screening (Pap smear)
  - Cervical cancer vaccine
  - Childhood immunizations
  - Chlamydia screening
  - Cholesterol screening
  - Colorectal cancer screening (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test)

*Office visit copayment or coinsurance may apply and/or be subject to a deductible. Age limitations and frequencies may apply.

A detailed listing of eligible procedures and services follows.

Procedure Codes	Descriptions
Immunizations	
90460-90461, 90471-90474	Immunization administration
90632-90634	Hepatitis A
90636	HepA-HepB adult
90644, 90733-90734	Meningococcal
90620-90621	MenB ages 16-23
90647-90648	Hib
90649 90650-90651	HPV quadrivalent 3 dose ages 9-26 HPV bivalent 3 dose ages 9-26
90630, 90653-90658, 90660-90662, 90664, 90666-90668, 90672, 90673, 90674, 90685-90688, Q2034-Q2039	Influenza
90670, 90732	Pneumococcal
90680-90681	Rotavirus

Procedure Codes	Descriptions	
90696	DTaP-IPV ages 4-6	
90697	DTap-IPV-Hib-HepB	
90698	DTaP-Hib-IPV	
90700	DTaP < 7 years	
90702	DT < 7 years	
90707	Measles, mumps and rubella (MMR)	
90710	Measles, mumps, rubella and varicella vaccine (MMRV)	
90713	Poliovirus (IPV)	
90714	Td 7 years and older	
90715	Tdap 7 years and older	
90716	Varicella (VZV) – chicken pox	
90723	DTaP-HepB-IPV	
90736	Herpes Zoster (shingles) ages 60 and older	
90739, 90740, 90743, 90744, 90746, 90747	Hepatitis B	
90748	HepB-Hib	
G0008	Administration of influenza virus vaccine	
G0009	Administration of pneumococcal vaccine	
G0010	Administration of hepatitis B vaccine	
Alcohol Screenings		
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention (SBI) services; 15 to 30 minutes)	Four visits per year
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Four visits per year
G0442	Annual alcohol misuse screening, 15 minutes	
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	Four visits per year
Bone Density		
76977, 77078, 77080, 77081, G0130	DXA, bone density study	One per lifetime for ages 65 and older

Procedure Codes	Descriptions	
Cholesterol		
80061	Lipid profile	Once every 5 years for men ages 35 and older; women ages 45 and older Once every 5 years for men ages 20-35; women ages 20-45 (with Z13.6, Z82.41-Z82.49)
82465	Cholesterol, serum or whole blood, total	Once every 5 years for men ages 35 and older; women ages 45 and older Once every 5 years for men ages 20-35; women ages 20-45 (with Z13.6, Z82.41-Z82.49)
83718	Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	Once every 5 years for men ages 35 and older; women ages 45 and older Once every 5 years for men ages 20-35; women ages 20-45 (with Z13.6, Z82.41-Z82.49)
83721	Lipoprotein, direct measurement; LDL cholesterol	Once every 5 years for men ages 35 and older; women ages 45 and older Once every 5 years for men ages 20-35; women ages 20-45 (with Z13.6, Z82.41-Z82.49)
84478	Triglycerides	Once every 5 years for men ages 35 and older; women ages 45 and older Once every 5 years for men ages 20-35; women ages 20-45 (with Z13.6, Z82.41-Z82.49)
Colorectal		
G0104	Colorectal cancer screening, flexible sigmoidoscopy	Once every 5 years starting at age 50
G0105	Colorectal cancer screening, colonoscopy	Once every 10 years starting at age 50
G0106	Colorectal cancer screening, alternative to G0104, screening sigmoidoscopy, barium enema	Once every 5 years starting at age 50
G0120	Colorectal cancer screening, alternative to G0105, screening colonoscopy, barium enema	Once every 10 years starting at age 50
G0121	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk	Once every 10 years starting at age 50
G0328	Colorectal cancer screening, fecal occult blood test, immunoassay, 1-3 simultaneous determinations	Annually starting at age 50
45330, 45331-PT, 45338-PT	Flexible sigmoidoscopy	Once every 5 years starting at age 50

Procedure Codes	Descriptions	
45378-PT, 45380-PT, 45384-PT, 45385-PT, 45388-PT, G6024-PT	Colonoscopy, flexible	Once every 10 years starting at age 50
82270, 82274	Blood occult screening	Annually starting at age 50
Diabetes		
82947	Glucose (fasting blood sugar)	
82950	Glucose, post prandial	
82951	Glucose, tolerance test	
G0108	Diabetes self-management training, individual session (two or more), 30 minutes	
G0109	Diabetes self-management training, group session (two or more), 30 minutes	
HIV		
86689	Antibody, HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	
86701	Antibody, HIV-1	
86702	Antibody, HIV-2	
86703	Antibody, HIV-1 and HIV-2, single assay	
G0475	HIV antigen/antibody, combination assay, screening	
87389	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87390	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-1	
87391	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-2	
G0432, G0433, G0435	Infection agent antibody detection	
S3645	HIV-1 antibody testing of oral mucosal transudate	
Men's Health		
G0102	Digital rectal exam	
76706	Ultrasound AAA screening	One per lifetime for men ages 65-75
Newborn		
84030	Phenylalanine (PKU)	
84443	Thyroid stimulating hormone (TSH)	
85660	Sickling of RBC, reduction	

Procedure Codes	Descriptions	
85014, 85018	Anemia test	Age 21 and younger With diagnosis code Z00.121-Z00.129
83655	Lead screening	Age 21 and younger With diagnosis code Z00.121-Z00.129
86580	TB testing	Age 21 and younger With diagnosis code Z00.121-Z00.129
80061, 82465, 83721, 84478	Dyslipidemia screening	Age 21 and younger With diagnosis code Z00.121-Z00.129, Z13.220
Sexually Transmitted Diseases		
G0445	Semiannual high-intensity behavioral counseling to prevent STIs. Includes education, skills training and guidance on how to change sexual behavior.	Two every 12 months
86592-86593	Syphilis test	
87270, 87320, 87490- 87492, 87810	Chlamydia	
87850, 87590-87592	Gonorrhea	
87623-87625, G0476	Papillomavirus (HPV)	Screening should begin at 30 years of age and should occur no more frequently than every three years.
Women's Health		
P3000-P3001, Q0091, R923	Pap smear	
G0101	Cervical or vaginal cancer screening, pelvic and breast exam	
G0123, G0124, G0141, G0143-G0145, G0147-G0148	Screening cytopathology, cervical or vaginal	
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175	Cytopathology, cervical or vaginal	
E0602	Breast pump, manual	
Women's Health—Contraceptive Management * (with Diagnosis) *For members with pharmacy benefits, a listing of contraceptives covered at the pharmacy can be found at HealthAlliance.org.		
A4261	Cervical cap for contraceptive use	
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	
A4266	Diaphragm for contraceptive use	
S4989, J7297, J7298, J7301, J7307	Contraceptive intrauterine device (IUD), including implants and supplies	
J1050	Medroxyprogesterone acetate	
57170	Diaphragm or cervical cap fitting with instructions	

Procedure Codes	Descriptions	
58300, 58301	Insertion and removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600, 58605, 58611	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip or Falope ring)	
Women's Health—Mammography		
77067, 77063, G0202, R403	Screening mammography	Once a year ages 35 and up
96040	Medical genetics counseling (for BRCA)	With diagnosis code Z80.3
Women's Health—Obstetric Exams and Screening With Maternity Diagnosis		
80055, 80081	Obstetric profile	
81000-81002	Urinalysis	
83540	Iron	
85007, 85009	Differential WBC count	
85025, 85027	Automated hemogram	
86762	Antibody, rubella	
86850	Transfusion screen	
86900, 86901	Blood typing	
87086, 87088	Urine culture/colony count; urine bacteria	
87340-87341	Hepatitis B surface antigen detection	
87350	Hepatitis B antigen (HBeAg)	
85004	Blood count; automated differential WBC	
Smoking Cessation		
99406, 99407	Smoking and tobacco use cessation counseling visit	
Miscellaneous		
G0117, G0118	Glaucoma screening	
92551	Hearing screening, pure tone	Age 21 and younger
G0270, G0271, 97802-97804	Medical nutrition therapy	With diagnosis codes E08.00-E13.9, E71.30-E75.6, E77.0-E88.9, I10, I25.10-I25.9, I50.20-I50.9, J41.0-J44.9, N18.1-N18.9, O24.410-O24.439, O99.810, O99.815, Z48.22, Z94.0

Procedure Codes	Descriptions	
G0444	Annual depression screening; 15 minutes	
G0446	Biannual face-to-face intensive behavioral therapy to reduce CVD risk; 15 minutes	
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	26 every 12 months with diagnosis codes Z68.30-Z68.45
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	
G0472, 86803	Hepatitis C screening	Annually for high risk. Once per lifetime for adults born between 1945 and 1965.
99173	Screening test of visual activity	Age 21 and younger
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	
96110	Developmental testing	
99188	Application of fluoride varnish	Ages 0-6
G0297	Low dose CT for lung cancer screening	Annually ages 55 to 80
Preventive Care Exams		
99381-99387, 99391-99397	Preventive medicine services	
99401-99404, 99411, 99412	Preventive counseling	
R770	Preventive care services	
R771	Preventive care services vaccine administration	
R779	Other preventive services	

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EXHIBIT 1

BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS
EFFECTIVE 5/1/2018THROUGH 12/31/2018

This "EXHIBIT 1" is to be used in conjunction with the "Preventive Care Services" and "Well-Child Care Services" subsections of the "MEDICAL BENEFITS—ELIGIBLE EXPENSES" section of this Plan. Covered Persons may also receive a hard copy of the information contained in this "EXHIBIT 1" section in a brochure-type format.

For questions related to this "EXHIBIT 1" section, contact the Third Party Administrator's Customer Service Department at the phone number listed in the "GENERAL PLAN INFORMATION" section of this document.

Following is a partial list of the services included in your comprehensive preventive care services benefit:*****

- One preventive care exam per Covered Person (no age limitations) per Benefit Period
- One preventive care visit to a woman's principal healthcare Provider per year
- Well-child care
- The screenings, procedures and immunizations listed below, within the applicable preventive care services benefit:
  - Blood sugar screening
  - Cervical cancer screening (Pap smear)
  - Cervical cancer vaccine
  - Childhood immunizations
  - Chlamydia screening
  - Cholesterol screening
  - Colorectal cancer screening (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test)

*****Office visit Copayment and Coinsurance may apply.

A detailed listing of preventive care procedures and services follows.

Procedure Codes	Descriptions
Immunizations	
90460–90461, 90471–90474	Immunization administration
90632–90634	Hepatitis A
90636	HepA-HepB adult
90644, 90733–90734	Meningococcal
90620–90621	MenB ages 16-23
90647–90648	Hib
90649 90650-90651	HPV quadrivalent 3 dose ages 9-26 HPV bivalent 3 dose ages 9-26
90630, 90653–90658, 90660–90662, 90664, 90666–90668, 90672, 90673, 90674, 90682, 90685–90688, 90756, Q2034–Q2039	Influenza
90670, 90732	Pneumococcal

Procedure Codes	Descriptions	
90680–90681	Rotavirus	
90696	DTaP-IPV ages 4-6	
90697	DTap-IPV-Hib-HepB	
90698	DTaP-Hib-IPV	
90700	DTaP < 7 years	
90702	DT < 7 years	
90707	Measles, mumps and rubella (MMR)	
90710	Measles, mumps, rubella and varicella vaccine (MMRV)	
90713	Poliovirus (IPV)	
90714	Td 7 years and older	
90715	Tdap 7 years and older	
90716	Varicella (VZV) – chicken pox	
90723	DTaP-HepB-IPV	
90750	Herpes Zoster (shingles) ages 50 and older	
90739, 90740, 90743, 90744, 90746, 90747	Hepatitis B	
90748	HepB-Hib	
G0008	Administration of influenza virus vaccine	
G0009	Administration of pneumococcal vaccine	
G0010	Administration of hepatitis B vaccine	
Alcohol Screenings		
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention (SBI) services; 15 to 30 minutes)	Four visits per year
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Four visits per year
G0442	Annual alcohol misuse screening, 15 minutes	
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	Four visits per year
Osteoporosis Screening		
76977, 77078, 77080, 77081, G0130	DXA, bone density study	

Procedure Codes	Descriptions	
Cholesterol		
80061	Lipid profile	Once every 5 years ages 20 and older, and children at high risk
82465	Cholesterol, serum or whole blood, total	Once every 5 years ages 20 and older, and children at high risk
83718	Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	Once every 5 years ages 20 and older, and children at high risk
83721	Lipoprotein, direct measurement; LDL cholesterol	Once every 5 years ages 20 and older, and children at high risk
84478	Triglycerides	Once every 5 years ages 20 and older, and children at high risk
Colorectal		
G0104	Colorectal cancer screening, flexible sigmoidoscopy	Once every 5 years ages 50–75
G0105	Colorectal cancer screening, colonoscopy	Once every 10 years ages 50–75
G0106	Colorectal cancer screening, alternative to G0104, screening sigmoidoscopy, barium enema	Once every 5 years ages 50–75
G0120	Colorectal cancer screening, alternative to G0105, screening colonoscopy, barium enema	Once every 10 years ages 50–75
G0121	Colorectal cancer screening, colonoscopy on individual not meeting criteria for high risk	Once every 10 years ages 50–75
G0328	Colorectal cancer screening, fecal occult blood test, immunoassay, 1-3 simultaneous determinations	Annually starting at age 50
45330, 45331-PT, 45338-PT	Flexible sigmoidoscopy	Once every 5 years ages 50–75
45378-PT,45380-PT, 45384-PT, 45385-PT, 45388-PT	Colonoscopy, flexible	Once every 10 years ages 50–75
81528	Cologuard SERVICE ONLY COVERED WHEN SCREENING; DIAGNOSTIC SERVICES ARE NOT COVERED FOR COLOGUARD	Once every 3 years with diagnosis code Z12.11 or Z12.12; ages 50–75
Diabetes		
82947, 82950–82951	Abnormal blood glucose and Type 2 Diabetes Mellitus screening	
83036	Hemoglobin A1C	Once per year with diagnosis code Z00.00, Z00.01 or Z13.1
G0108	Diabetes self-management training, individual session (two or more), 30 minutes	G0108

Procedure Codes	Descriptions	
G0109	Diabetes self-management training, group session (two or more), 30 minutes	G0109
HIV		
86689	Antibody, HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	
86703	Antibody, HIV-1 and HIV-2, single assay	
87389	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87806	HIV-1 Antigen with HIV-1 HIV-2 antibodies	
G0432, G0433, G0435	Infection agent antibody detection	
G0475	HIV antigen/antibody, combination assay, screening	
Men's Health		
76706	Ultrasound AAA screening	One per lifetime for men ages 65-75
G0102	Digital rectal exam	
Newborn		
84030	Phenylalanine (PKU)	Ages 0–28 days
84437, 84443	Congenital hypothyroidism screening	Ages 0–90 days
85660	Sickle cell screening	
85014, 85018	Anemia test	Age 21 and younger With diagnosis code Z00.121–Z00.129
83655	Lead screening	Age 21 and younger With diagnosis code Z00.121–Z00.129
80061, 82465, 83721, 84478	Dyslipidemia screening	Age 21 and younger With diagnosis code Z00.121–Z00.129, Z13.220
S3620	Newborn metabolic screening panel	Ages 0–28 days
Sexually Transmitted Diseases		
G0445	Semiannual high-intensity behavioral counseling to prevent STIs. Includes education, skills training and guidance on how to change sexual behavior.	Two every 12 months
86592–86593	Syphilis test	With diagnosis code Z00.00, Z00.01, Z00.121, Z00.129. Z11.3, or Z20.2
87270, 87320, 87490–87492, 87810	Chlamydia	
87850, 87590–87592	Gonorrhea	

Procedure Codes	Descriptions	
87623–87625, G0476	Papillomavirus (HPV)	Screening should begin at 30 years of age and should occur no more frequently than every three years.
Women's Health		
P3000–P3001, Q0091, R923	Pap smear	
G0101	Cervical or vaginal cancer screening, pelvic and breast exam	
G0123, G0124, G0141, G0143–G0145, G0147-G0148	Screening cytopathology, cervical or vaginal	
88141–88143, 88147, 88148, 88150, 88152–88155, 88164-88167, 88174–88175	Cytopathology, cervical or vaginal	
E0602	Breast pump, manual	
Women's Health—Contraceptive Management * (with Diagnosis) *For Covered Persons with Pharmacy benefits, a listing of Contraceptives that are considered Eligible Expenses can be found at HealthAlliance.org.		
A4261	Cervical cap for contraceptive use	
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	
A4266	Diaphragm for contraceptive use	
S4989, J7296–J7298, J7301	Contraceptive intrauterine device (IUD), including implants and supplies	
J7307	Contraceptive non-biodegradable drug implant and supplies	
J1050, 96372	Medroxyprogesterone acetate and administration	
11982, 11983	Insertion and removal of non-biodegradable implant	
57170	Diaphragm or cervical cap fitting with instructions	
58300, 58301	Insertion and removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600, 58605, 58611	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g. band, clip or Falope ring)	
Women's Health—Breast Cancer Screening		
77067, 77063, G0202, R403	Screening mammography	Once a year ages 35 and up
96040	Medical genetics counseling (for BRCA)	With diagnosis code Z80.3
Women's Health—Obstetric Exams and Screening With Maternity Diagnosis		
80055, 80081	Obstetric profile	

Procedure Codes	Descriptions	
81000–81002	Urinalysis	
82950–82951	Gestational Diabetes Mellitus screening	
83540	Iron	
85007, 85009	Differential WBC count	
85025, 85027	Automated hemogram	
86762	Antibody, rubella	
86850, 86900–86901	Rh(D) Incompatibility screening	
87086, 87088	Urine culture/colony count; urine bacteria	
87340–87341	Hepatitis B surface antigen detection	
85004	Blood count; automated differential WBC	
Tobacco Use Cessation		
99406, 99407	Smoking and tobacco use cessation counseling visit	
Miscellaneous		
G0117, G0118	Glaucoma screening	
86480–86481, 86580	Tuberculosis (TB) screening	With diagnosis code Z00.00, Z00.129, or Z11.1
92551	Hearing screening, pure tone	Age 21 and younger
G0444	Annual depression screening; 15 minutes	
96127	Behavioral assessment	With diagnosis code Z13.89
G0446	Annual face-to-face intensive behavioral therapy to reduce CVD risk; 15 minutes	
G0447	Face-to-face behavioral counseling for obesity, individual, 15 minutes	26 every 12 months with diagnosis codes Z68.30–Z68.45
G0473	Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes	
G0499	Hepatitis B screening	
G0472, 86803	Hepatitis C screening	Annually for high risk. Once per lifetime for adults born between 1945 and 1965.
99173	Vision screening test	Age 21 and younger
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	
96110	Developmental testing	
99188	Application of fluoride varnish	Ages 0–6
G0296	Visit to determine low dose CT eligibility	With diagnosis code Z87.891
G0297	Low dose CT for lung cancer screening	Annually ages 55–80
Preventive Care Exams		
99381–99387, 99391–99397	Preventive medicine services	
99401–99404, 99411, 99412	Preventive counseling	

Procedure Codes	Descriptions
R770	Preventive care services
R771	Preventive care services vaccine administration
R779	Other preventive services

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ADDENDUM A-6

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Covered Person should contact the Plan Administrator/Plan Sponsor at the address or telephone number listed in the "GENERAL PLAN INFORMATION" section of this document to obtain additional information about eligibility for Plan coverage.

ELIGIBILITY

Eligible Classes of Employees. Eligible classes of Employees include all Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a full-time, Active Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is in a class eligible for coverage.

An Employee's status as a full-time or part-time Employee will be determined on the basis of the average number of hours worked during an initial or standard look-back measurement period, as applicable, as established by the Employer in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her full-time or part-time status will extend through the stability period established by the Employer in accordance with applicable law. In calculating the average hours worked, the Employer will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation pay, etc.).

For these purposes, a "look-back measurement period" means the period established by the Employer of at least three but not more than 12 consecutive months for purposes of determining an Employee's initial or ongoing eligibility for coverage. The initial look-back measurement period and the standard look-back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look-back measurement period (including any administrative period established by the Employer which may follow those look-back periods).

Eligible Classes of Employee's Dependents. A Dependent is considered any one of the following persons:

(1) A covered Employee's Spouse.

The Plan may require documentation proving a legal marital relationship.

(2) A covered Employee's Domestic Partner.

An individual is considered a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole Domestic Partner. Each of the foregoing characteristics of the Domestic Partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the coverage is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this coverage, the Employee must contact the Employer.

In the event the domestic partnership is terminated, either partner is required to inform the Employer of the termination of the partnership.

The Plan may require documentation proving a legal Domestic Partner relationship.

(3) A covered Employee's child(ren). An Employee's "child" includes his or her:

(a) natural child;

(b) stepchild (as long as the natural parent remains married to the Employee);

(c) adopted child or a child who is placed for adoption with the Employee or Employee's Spouse;

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(d) child for whom the Employee or Employee's Spouse is appointed Legal Guardian;

(e) child who is an alternate recipient under a qualified medical child support order.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator/Plan Sponsor.

The Plan Administrator/Plan Sponsor may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(f) natural child, stepchild, adopted child, or child for whom the Employee is appointed Legal Guardian, as described above, who is age 26 or over and Totally Disabled on the date of enrollment, provided such child's Total Disability commenced prior to his or her attaining age 26. Such child must be (i) incapable of self-sustaining employment by reason of mental or physical handicap, (ii) primarily dependent upon the covered Employee for support and maintenance, and (iii) unmarried. In addition, the Employee must remain covered under the Plan and the additional contributions, if any, must be paid for the Totally Disabled child to be covered. Proof of the Dependent child's Total Disability is required. See the subsection "Submitting Proof of a Dependent Child's Total Disability" for requirements.

An Employee's child will be considered an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month, unless such child is Totally Disabled on that date, in which case, coverage may be continued if Plan requirements are met (see below). Proof of Total Disability, as well as proof of continued Total Disability may be required from time to time.

(4) A covered Employee's covered Domestic Partner's child(ren). A Domestic Partner's "child" includes his or her:

(a) natural child;

(b) adopted child or child who is placed for adoption with the Domestic Partner;

(c) child for whom the Domestic Partner is appointed Legal Guardian;

(d) child who is an alternate recipient under a qualified medical child support order.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator/Plan Sponsor.

The Plan Administrator/Plan Sponsor may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(e) natural child, adopted child, or child for whom the Domestic Partner is appointed Legal Guardian, as described above, who is age 26 or over and Totally Disabled on the date of enrollment, provided such child's Total Disability commenced prior to his or her attaining age 26. Such child must be (i) incapable of self-sustaining employment by reason of mental or physical handicap, (ii) primarily dependent upon the covered Domestic Partner for support and maintenance, and (iii) unmarried. In addition, the Domestic Partner must remain covered under the Plan and the additional contributions, if any, must be paid for the Totally Disabled child to be covered. Proof of the Dependent child's Total Disability is required. See the subsection "Submitting Proof of a Dependent Child's Total Disability" for more information.

A Domestic Partner's child will be considered an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Domestic Partner or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month, unless such child is Totally Disabled on that date, in which case, coverage may be continued if Plan requirements are met (see below). Proof of Total Disability, as well as proof of continued Total Disability may be required from time to time.

(5) A covered Employee's qualified Dependent child(ren). An Employee's qualified Dependent child includes his or her:

(a) unmarried child over age 26 but less than 30 years of age if a veteran and an Illinois resident who served in the Armed Forces of the United States of America and who has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the eligible child who is a veteran shall submit to the Plan Administrator/Plan Sponsor a form approved by the Illinois Department of Veterans' Affairs stating the date on which he or she was released from service.

When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

(6) A covered Dependent child, as described above, who would otherwise lose coverage when he or she reaches the limiting age, and all of the following conditions are met:

(a) The child is Totally Disabled;

(b) The child is incapable of self-sustaining employment by reason of mental or physical handicap;

(c) The child is primarily dependent upon the covered Employee for support and maintenance; and

(d) The child is unmarried.

Proof of the Dependent child's Total Disability is required. See the subsection "Submitting Proof of a Dependent Child's Total Disability" for more information.

If both parents are Employees, their children will be covered as Dependents of one parent or the other, but not of both.

Submitting Proof of a Dependent Child's Total Disability. With regard to a Totally Disabled Dependent child, within 31 days of a Totally Disabled child becoming newly-enrolled or reaching the limiting age, the Employee/Employee's

Domestic Partner shall furnish the Plan Administrator/Plan Sponsor with documentation from the child's attending Physician pertaining to the child's Total Disability. The Plan must approve the request for coverage under this provision of the Plan in order for coverage to become effective or remain in effect. A Totally Disabled child must satisfy all of the following conditions:

- The child is Totally Disabled;
- The child is incapable of self-sustaining employment by reason of mental or physical handicap;
- The child is primarily dependent upon the covered Employee for support and maintenance; and
- The child is unmarried.

The Plan Administrator/Plan Sponsor may require, at reasonable intervals, subsequent proof of the child's Total Disability and dependency, generally not more than once each year; however, if the child's condition is such that there may be improvement significant enough to affect the child's eligibility under the Plan, the Plan Administrator/Plan Sponsor reserves the right to require more-frequent evaluation, or to have the Dependent child examined by a Physician of the Plan Administrator's/Plan Sponsor's choice, at the Plan's expense, to determine the existence of Total Disability.

Tax Treatment for Certain Dependents. Federal tax law generally does not recognize former Spouses, Legally-Separated Spouses or Domestic Partners, or the children of these partners, as dependents under the federal tax code unless the Spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code § 152. Therefore, the Employer may be required to automatically include the value of the healthcare coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

Persons Excluded as Dependents. The following persons are excluded as Dependents under this Plan:

(1) Any person who is not a resident of the United States of America;

(2) Other individuals living in the covered Employee's home, but who are not eligible as defined;

(3) The Legally Separated or divorced former Spouse of the covered Employee;

(4) Any Civil Union partner from whom the covered Employee is Legally Separated or has received a dissolution of the partnership;

(5) Any former Domestic Partner of the covered Employee;

(6) Any child of a Civil Union partner from whom the covered Employee is Legally Separated or has received a dissolution of the partnership;

(7) Any child of a former Domestic Partner of the covered Employee;

(8) Any person who is covered under the Plan as an Employee;

(9) Any person who is on active duty in any military service of any country;

(10) Foster children;

(11) Grandchild(ren) (unless the child is placed for adoption with the covered Employee or covered Employee's Spouse/Domestic Partner while adoption proceedings with respect to that child by the Employee or Employee's Spouse/Domestic Partner are pending, the child is legally adopted by the covered Employee or covered Employee's Spouse/Domestic Partner, or the covered Employee or covered Employee's Spouse/Domestic Partner is appointed Legal Guardian).

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or Domestic Partner or Dependent child qualifies or continues to qualify as a Dependent as defined by this Plan.

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Qualified Medical Child Support Order (QMSCO). A Qualified Medical Child Support Order is an order that creates or recognizes a Dependent child's right to receive benefits under the Plan. The term "Qualified Medical Child Support Order" also includes a National Medical Child Support Notice. A support order may be issued by a state court or through a state administrative process. If an Employee has a Dependent child and the Employer receives a Medical Child Support Order identifying the child's right to enroll in the Plan, the Employer will notify both the Employee and the child that the order has been received. The notification will also indicate the Plan's procedure for determining whether the Medical Child Support Order is qualified.

To be considered a Qualified Medical Child Support Order, the order must clearly specify all of the following:

(1) The Employee's name and last known mailing address.

(2) The name and mailing address of the Dependent child specified in the order.

(3) A reasonable description of the type of coverage to be provided to the Dependent child, or the manner in which the type of coverage will be determined.

(4) The period to which the order applies.

(5) The name of the plan to which the order applies.

The Dependent child's eligibility for enrollment will be under the same terms and conditions as other Dependents.

The Plan Administrator/Plan Sponsor or its designee will notify the Employee whether or not the child is eligible for coverage within 31 days of receipt of the order. If the Employer offers more than one plan option, the child will be enrolled in the same plan in which the Employee is enrolled. The Plan Administrator/Plan Sponsor does not need approval from the Employee to add the child to the Plan under a Qualified Medical Child Support Order.

The Dependent child may designate another person, such as a custodial parent or Legal Guardian, to receive the Plan Document/Summary Plan Description, reimbursement for claims, explanation of benefit forms and other Plan materials.

If the Plan Administrator/Plan Sponsor decides that the order is not a Qualified Medical Child Support Order, each Dependent child specified in the order as entitled to enroll in the Plan may submit a written appeal to the Plan Administrator/Plan Sponsor.

The Employer will not disenroll or eliminate coverage of any such child until any of the following apply:

(1) Satisfactory written evidence is provided that the order is no longer effective.

(2) Comparable coverage through another plan will take effect no later than the disenrollment date.

(3) The Employer eliminates Dependent coverage for all Covered Persons.

(4) The Employer terminates the Plan for all Covered Persons.

Enrollment of a Dependent child in response to a Qualified Medical Child Support Order will be made upon the later of the date specified in the order or the date the Plan Administrator/Plan Sponsor determines that the order is a Qualified Medical Child Support Order.

Copies of the Plan's procedures governing Qualified Medical Child Support Orders and a sample Qualified Medical Child Support Order may be obtained without charge by contacting the Plan Administrator/Plan Sponsor.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the Employee elects to provide coverage for his or her Dependents, then the covered Employee is required to enroll for Dependent coverage also. For more details about the enrollment process, the Employee may contact the Employer at the telephone number or website listed in the "GENERAL PLAN INFORMATION" section of this document.

ADDENDUM A-6

Enrollment Requirements for Newborn Children. If a covered Employee has family coverage, coverage under the Plan is automatically provided for his or her newborn child for the first 31 days of birth. In order for the newborn's coverage to continue beyond the first 31 days after birth, the Employee must complete and submit an enrollment application to the Employer within 31 days of the newborn's date of birth to add the newborn. If an enrollment application is not completed and submitted to the Employer on a timely basis, the newborn's coverage will terminate at the end of the 31st day after birth and no further benefits would be available under the Plan.

If a covered Employee has single coverage, his or her newborn child is covered under the Plan only if a completed enrollment application is submitted to the Employer within 31 days of the newborn's date of birth.

If application for coverage is made after the 31-day period, the covered Employee's newborn child will be considered a Late Enrollee. (See the subsection below titled "TIMELY, LATE AND OPEN ENROLLMENT—Late Enrollment.")

Note that the "Continuation Coverage Rights under COBRA" provisions of this Plan will not be applicable to a newborn child who is not enrolled in the Plan.

Enrollment Requirements for Adopted Children. If a covered Employee has family coverage, coverage under the Plan is provided for his or her adopted child: (i) on the date a court makes a final order granting adoption of the child by the covered Employee; or (ii) on the date that the child is placed for adoption with the covered Employee, whichever occurs first.

If a covered Employee has single coverage and wishes to change his or her coverage to add a newly-eligible Dependent because of his or her adoption of a child or a child placed for adoption, the covered Employee must apply for coverage within 31 days of the date of such adoption or placement for adoption. If application for coverage is made after the 31-day period, the covered Employee's new Dependent child will be considered a Late Enrollee. (See the subsection below titled "TIMELY, LATE AND OPEN ENROLLMENT—Late Enrollment.")

If the adoption of a child who is placed for adoption with the covered Employee is not finalized, the child's coverage under the Plan will terminate when the child's adoptive placement with the covered Employee terminates. Note that the "Continuation Coverage Rights under COBRA" provisions of this Plan will not be applicable to an adopted child who is not enrolled in the Plan.

TIMELY ENROLLMENT, LATE ENROLLMENT AND OPEN ENROLLMENT

(1) **Timely Enrollment—**An enrollment is considered "timely" if the completed enrollment form is received by the Employer no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are married to each other/in a Domestic Partner relationship with each other are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment**—An enrollment is considered "late" if it is not made on a timely basis or during a Special Enrollment Period. Individuals who satisfy the eligibility requirements of the Plan but do not enroll in the Plan within 31 days of initially becoming eligible or during a Special Enrollment Period are considered Late Enrollees. Late Enrollees may only enroll in the Plan during the annual Open Enrollment period. Late Enrollees are not eligible to enroll in the Plan at any other time.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining if the individual is considered a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(3) **Open Enrollment**—Each November, the Plan Administrator/Plan Sponsor will hold an annual Open Enrollment period.

During the annual Open Enrollment period, individuals who are considered Late Enrollees will have the opportunity to enroll in the Plan.

Benefit and coverage choices made during the Open Enrollment period will become effective January 1 and remain in effect until the next January 1, unless there is a change in family status (birth, adoption, death, marriage, Civil Union, registration of domestic partnership, divorce, dissolution of Civil Union/domestic partnership) during the year, or a loss of coverage due to the loss of a Spouse's or Domestic Partner's employment.

Eligible individuals will receive detailed information regarding Open Enrollment from the Plan Administrator/Plan Sponsor.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under certain circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment under this Plan must be made within 31 days after the other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, Civil Union, Domestic Partner relationship, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, Civil Union, registration of the Domestic Partner relationship, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator/Plan Sponsor at the address or telephone number listed in the "GENERAL PLAN INFORMATION" section of this document.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in this Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator/Plan Sponsor, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for that coverage or because employer contributions towards that coverage were terminated.

(d) In this case, the Employee or Dependent must request enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions.

Coverage under this Plan will begin on the date following the date of the loss of the other coverage.

For purposes of these rules, a loss of eligibility under the other coverage occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of Legal Separation, divorce, dissolution of Civil Union or Domestic Partner relationship, cessation of dependent status (such as

attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right under this Plan.

(2) Acquiring a newly-eligible Dependent may create a Special Enrollment right. If:

(a) the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) a person becomes a Dependent of the Employee through marriage, Civil Union, or registration of a Domestic Partner relationship,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

(c) a person becomes a Dependent of the Employee through birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse/Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse/Domestic Partner is otherwise eligible for coverage. Previously-eligible but not enrolled Dependent children of the covered Employee may also be enrolled as Dependents of the covered Employee, If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, Civil Union, registration of a Domestic Partner relationship, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of a Dependent (and Employee) enrolling in the Plan under a Special Enrollment Period will be effective as follows:

(i) In the case of marriage, as of the date of the marriage; or

(ii) In the case of a Civil Union, as of the date of the Civil Union; or

(iii) In the case of a Domestic Partner relationship, as of the date of registration of the Domestic Partner relationship; or

(iv) In the case of a Dependent child's birth, as of the date of birth; or

(v) In the case of a Dependent child's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Eligibility changes in Medicaid and State Child Health Insurance Programs may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Plan (SCHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage.

The Employee or Dependent must request enrollment in this Plan within 60 days after such Medicaid or SCHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or SCHIP plan (including any waiver or demonstration project conducted with respect to such plan).

The Employee or Dependent must request enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage under this Plan will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

To learn more about these Medicaid and SCHIP plans, contact your state Medicaid or SCHIP office or dial 1-877-KIDS NOW (1-877-543-7669) or visit the website at www.insuredkidsnow.gov.

CHANGE-IN-STATUS EVENTS IN RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to certain qualifying change-in-status events under the Employer's Section 125 Cafeteria Plan. Refer to the Employer's Section 125 Cafeteria Plan for more information.

EFFECTIVE DATE

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) in order for Plan coverage to take effect.

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirements of the Plan.

(2) The Active Employee Requirement of the Plan.

(3) The Enrollment Requirements of the Plan.

An Employee who returns to active employment from a layoff or leave of absence is not required to satisfy the requirements specified above. Coverage under the Plan is effective immediately upon the Employee's return to active employment.

Change in Employment Status. An Employee who experiences a change in his or her employment status from part-time to full-time status is eligible for coverage under the Plan. In this case, the Employee's coverage will become effective as specified in the "Effective Date of Employee Coverage" subsection above.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the eligibility requirements are met; all enrollment requirements are met; and the Employee is covered under the Plan. In the case of a Dependent child who is eligible due to a qualifying change-in-status event, as outlined in the Employer's Section 125 plan, the Dependent child's coverage will take effect on the date that such child is eligible due to the qualifying change-in-status event.

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TERMINATION OF COVERAGE

NOTE: The Plan Administrator/Plan Sponsor has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim, or making an intentional material misrepresentation in applying for or obtaining coverage or benefits under the Plan. The Plan Administrator/Plan Sponsor may either void coverage for the covered Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's/Plan Sponsor's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if any claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. A covered Employee's coverage will terminate on the date determined by the Employer (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section titled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."). Reasons for termination of coverage include the following:

(1) The date on which the Plan is terminated.

(2) The date on which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.

This also includes an Employee on disability, layoff, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

(3) The date on which the covered Employee's Eligible Class is eliminated.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage or benefits under the Plan, or fails to notify the Plan Administrator/Plan Sponsor that he or she has become ineligible for coverage, then the Plan Administrator/Plan Sponsor may either void coverage for the covered Employee for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's/ Plan Sponsor's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator/Plan Sponsor will provide at least 30-days' advance-written notice of such action.

Continuation During Periods of Employer-Certified Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence or layoff. This continuance will end as follows:

- **For leave of absence only:** the end of the six calendar month-period that next follows the date in which the person last worked as an Active Employee, as long as the Employee pays 100 percent of the required premium. If the Employee fails to pay 100 percent of the required premium, coverage will end as of the last day of the month of the Employee's termination of employment from the Employer.

- **For layoff only:** the end of the six calendar month-period that next follows the date in which the person last worked as an Active Employee, as long as the Employee pays 100 percent of the required premium. If the Employee fails to pay 100 percent of the required premium, coverage will end as of the last day of the month of the Employee's termination of employment from the Employer.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If coverage under this Plan terminates during the FMLA leave, the coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired by the Employer will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements of the Plan.

Employees on Military Leave. Employees going into or returning from military service may elect to continue coverage under the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage for an Employee and his or her Dependents under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the Employee's absence begins; or

(b) The day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.

(2) An Employee who elects to continue health plan coverage must pay up to 102 percent of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator/Plan Sponsor at the address or telephone number listed in the "GENERAL PLAN INFORMATION" section of this document. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing coverage under USERRA as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for himself/herself and his/her Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A covered Dependent's coverage will terminate on the date determined by the Employer (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section titled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."). Reasons for termination of coverage include the following:

(1) The date on which the Plan or Dependent coverage under the Plan is terminated.

(2) The date on which the covered Employee's coverage under the Plan terminates for any reason including death.

(3) The date on which a covered Spouse or covered Domestic Partner ceases to meet the applicable eligibility requirements.

(4) The date on which a covered Dependent child ceases to meet the applicable eligibility requirements.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage or benefits under the Plan, or fails to notify the Plan Administrator/Plan Sponsor that he or she has become ineligible for coverage, then the Plan Administrator/Plan Sponsor may either void coverage for the covered Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's/Plan Sponsor's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator/Plan Sponsor will provide at least 30-days' advance-written notice of such action.

Dependent Continuation Coverage under Prior Group Accident or Health Insurance Policy. A person who had properly elected continuation coverage under the group accident or health insurance policy of the Employer prior to the date this Plan became effective with respect to the Employer pursuant to 215 ILCS §5/367.2 shall be entitled to coverage under this Plan in accordance with the terms and conditions established by the Plan (including the timely payment of contributions required for coverage) until:

(1) the date two years from the date continuation coverage began with respect to a former Spouse who has not attained age 55 on the date such continuation coverage commenced; or

(2) the date the former Spouse or retired Employee's Spouse, who has attained age 55 on the date such continuation coverage commenced, attains age 65.

Extension of Benefits. If coverage under the Plan would otherwise terminate with respect to a Covered Person without regard to the continuation of coverage provisions and limitations of the Plan, benefits under the Plan can nevertheless be extended under the specific circumstances specified in this Plan. A person for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order will be entitled to an extension of benefits only to the extent to which there is a legal requirement to provide such extension of benefits either based on applicable law, contractual agreement or court order.

IMPORTANT

Section 1557 of PPACA, a federal law, requires that you be provided this notice.

The notice does not change the terms of your coverage and/or benefits under your employer-sponsored health plan.

Please review the information and keep it with your plan materials.

NO FURTHER ACTION IS REQUIRED ON YOUR PART.

DISCRIMINATION IS AGAINST THE LAW

Health Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance, Customer Service, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan Ave., Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-851-3379; telephone for members in Washington: 1-877-750-3515 TTY: 711, fax: 217-902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame 1-800-851-3379, WA Llame: 1-877-750-3515 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 1-800-851-3379, WA: 呼叫 1-877-750-3515（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-851-3379, WA: Zadzwoń 1-877-750-3515 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-851-3379, WA: Gọi 1-877-750-3515 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 IA, IL, IN, OH: 전화 WA: 1-877-750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-851-3379, WA: Вызов 1-877-750-3515 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-851-3379, WA: Tumawag 1-877-750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-851-3379، ولاية واشنطن: اتصل بالرقم: 1-877-750-3515 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-851-3379, WA: Anruf 1-877-750-3515 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-851-3379, WA: Appelez 1-877-750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ 1-800-851-3379, WA: કૉલ 1-877-750-3515 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-851-3379 IA, IL, IN, OH: コール 1-877-750-3515 WA: コール（TTY: 711）。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-851-3379, WA: Bel 1-877-750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-851-3379, WA: Виклик 1-877-750-3515 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-851-3379, WA: Chiamare 1-877-750-3515 (TTY: 711).