This document is an amendment to Illinois Educators Risk Management Program Association's January 1, 2018 Plan Document ("PD")/Summary Plan Description ("SPD"). An amendment adds, deletes or otherwise changes the terms of the Plan. Changes made by amending the Plan may affect benefit provisions, limitations or administrative requirements to obtain a benefit. Please review this information carefully and keep it with the PD/SPD for reference.

Regarding:

1. **Updates to Plan Options**
2. **Medical Benefits—Eligible Expenses ("Acupuncture Treatment")**
3. **Plan Exclusions ("Acupuncture, Acupressure and Hypnotherapy")**
4. **Prescription Drug Benefits—Eligible Prescription Drug Expenses ("Epinephrine injectors")**
5. **General Plan Administration Information—Compliance With Applicable Law**
6. **Exhibit 3: Pharmacy Discount Program(s)**
7. **Exhibit 1: Be Healthy—Using Your Preventive Care Benefits, Effective 1/1/2019**

AMENDMENT TO THE
ILLINOIS EDUCATORS RISK MANAGEMENT PROGRAM ASSOCIATION
GROUP HEALTH PLAN

The following is an amendment to your **January 2018** Plan Document/Summary Plan Description. Please review this document carefully and keep it with your Plan Document/Summary Plan Description for future reference.

AMENDMENT #3, effective January 1, 2020, unless otherwise stated herein:

*On page 6, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**PPO 500d PLAN OPTION**" has been deleted in its entirety.*

*On page 11, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**PPO 1000d PLAN OPTION**" has been deleted in its entirety.*

*On page 16, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**PPO 2500 100% PLAN OPTION**" has been deleted in its entirety.*

*On pages 21–25, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**HDHP 3000 PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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

LIFETIME MAXIMUM BENEFITS	Your maximum benefit amount when using Preferred Providers and Non-Preferred Providers (combined)
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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	0% coinsurance, after deductible	0% coinsurance, after deductible (Preferred Provider benefit level applies)

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

PRESCRIPTION DRUG BENEFITS FOR 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
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*On pages 21–25, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**HDHP 5000 PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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

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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	0% coinsurance, after deductible	0% coinsurance, after deductible (Preferred Provider benefit level applies)
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

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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

PRESCRIPTION DRUG BENEFITS FOR 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

PRESCRIPTION DRUG BENEFITS FOR 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)**: 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
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*Under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", a new subsection "**POS 2500 80% PLAN OPTION**" has been added after the subsection "**HDHP 5000 PLAN OPTION**". This subsection reads as follows:*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS 2500 80% 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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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	$4,000	$8,000
Per Family Unit	$12,000	$24,000

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
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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	$25 copayment per visit (deductible waived)	$25 copayment per visit (deductible waived) (Preferred Provider benefit level applies)
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

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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
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 FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 copayment per script	50% coinsurance per script, after deductible

PRESCRIPTION DRUG BENEFITS FOR 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)	(deductible waived on all Tiers) **Tier 4 (preferred)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*On pages 31–35, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**POS 2500 100% PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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
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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	0% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	$25 copayment per visit (deductible waived)	$25 copayment per visit, (deductible waived) (Preferred Provider benefit level applies)
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

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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
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 FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 copayment per script	50% coinsurance per script, after deductible

PRESCRIPTION DRUG BENEFITS FOR 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)	(deductible waived on all Tiers) **Tier 4 (preferred)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*On pages 36–40, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**POS-C 1000d PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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*

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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
Office Visit—Specialty Care	$50 copayment per visit	50% coinsurance, after deductible
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance	50% coinsurance, after deductible
Acupuncture treatment [1]	$25 copayment per visit	$25 copayment per visit (Preferred Provider benefit level applies)
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

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

PRESCRIPTION DRUG BENEFITS FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 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)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 copayment per script	50% coinsurance per script, after deductible

PRESCRIPTION DRUG BENEFITS FOR ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*On pages 41–45, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**POS-C 2000d PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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

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
Office Visit—Specialty Care	$50 copayment per visit	50% coinsurance, after deductible
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance	50% coinsurance, after deductible
Acupuncture treatment [1]	$25 copayment per visit	$25 copayment per visit (Preferred Provider benefit level applies)

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	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
Temporomandibular Joint (TMJ) Disorder [1, 4]	20% coinsurance	50% coinsurance, after deductible
Other Services/Benefits	20% coinsurance	50% coinsurance, after deductible

PRESCRIPTION DRUG BENEFITS FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 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)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*Under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", a new subsection "**POS-C+ 1000 PLAN OPTION**" has been added after the subsection "**POS-C 200d PLAN OPTION**". This subsection reads as follows:*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS

POS-C+ 1000 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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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	$5,000
Per Family Unit	$1,000	$10,000

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	$3,500	$10,000
Per Family Unit	$7,000	$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, after deductible	50% coinsurance, after deductible
Hospital Care	$1,000 copayment per admission, then 20% coinsurance, after deductible	50% coinsurance, after deductible
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	$1,000 copayment per admission, then 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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	$25 copayment per visit (deductible waived)	$25 copayment per visit (deductible waived) (Preferred Provider benefit level applies)
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	$1,000 copayment per procedure, then 20% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	20% coinsurance, after deductible	50% coinsurance, after deductible

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
Imaging (CT/PET scans, MRIs)	$500 copayment per procedure, then 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
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 FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 copayment per script	50% coinsurance per script, after deductible

PRESCRIPTION DRUG BENEFITS FOR ELIGIBLE EXPENSES	You Pay Preferred Provider/Pharmacy	You Pay Non-Preferred Provider/Pharmacy
Mail-Order Prescription Drugs (limited to a maximum 90-day supply)	(deductible waived on all Tiers) **Tier 1 (generic)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 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)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*Under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", a new subsection "**POS-C+ 2000 PLAN OPTION**" has been added after the newly added subsection "**POS-C+ 1000 PLAN OPTION**". This subsection reads as follows:*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
POS-C+ 2000 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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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	$750	$5,000
Per Family Unit	$1,500	$10,000

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	$4,750	$10,000
Per Family Unit	$9,500	$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, after deductible	50% coinsurance, after deductible
Hospital Care	$2,000 copayment per admission, then 20% coinsurance, after deductible	50% coinsurance, after deductible
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	$2,000 copayment per admission, then 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
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	50% coinsurance, after deductible
Routine Prenatal Care	20% coinsurance, after deductible	50% coinsurance, after deductible
Acupuncture treatment [1]	0% coinsurance, after deductible	0% coinsurance, after deductible (Preferred Provider benefit level applies)
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	$2,000 copayment per procedure, then 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)	$1,000 copayment per procedure, then 20% coinsurance, after deductible	50% coinsurance, after deductible
Home Health Care/Home Infusion Services	20% coinsurance, after deductible	50% coinsurance, after deductible

ELIGIBLE EXPENSES	You Pay Preferred Provider	You Pay Non-Preferred Provider
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
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 FOR 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)**: $10 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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)**: $27.50 copayment per script **Tier 2 (preferred brand)**: $110.00 copayment per script **Tier 3 (non-preferred brand)**: $220.00 copayment per script	50% coinsurance per script, after deductible

PRESCRIPTION DRUG BENEFITS FOR 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)	(deductible waived on all Tiers) **Tier 4 (preferred)**: 50% coinsurance per script **Tier 5 (non-preferred)**: 50% coinsurance 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)	(deductible waived on all Tiers) **Tier 1 (generic)**: $0 copayment per script **Tier 2 (preferred brand)**: $40 copayment per script **Tier 3 (non-preferred brand)**: $80 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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*On pages 46–49, under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", the subsection "**HMO 80 PLAN OPTION**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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	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.

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*
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	*Not considered an Eligible Expense*
Routine Prenatal Care	20% coinsurance	*Not considered an Eligible Expense*
Acupuncture treatment [1]	$25 copayment per visit	*Not considered an Eligible Expense*

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	*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*
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 [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 FOR 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)**: $220.00 copayment per script	*Not considered an Eligible Expense*
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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.		

[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.

*Under the section "**SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS**", a new subsection "**HMO 80 $3000 PLAN OPTION**" has been added after the subsection "**HMO 80 PLAN OPTION**". This subsection reads as follows:*

SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS
HMO 80 $3000 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) (This limitation does not apply to the Autism Spectrum Disorders benefit.)
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
Acupuncture treatment	15 visits 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	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	$3,000	Not Applicable
Per Family Unit	$6,000	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.

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*
Telehealth Services	Primary Care or Specialty Care Office Visit benefit level applies	*Not considered an Eligible Expense*
Routine Prenatal Care	20% coinsurance	*Not considered an Eligible Expense*
Acupuncture treatment [1]	$25 copayment per visit	*Not considered an Eligible Expense*

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	*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*
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 [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 FOR 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)**: $220.00 copayment per script	*Not considered an Eligible Expense*
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*
Also see the "EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)" section.f		

[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.

*On page 51, under the section "**MEDICAL BENEFITS**", the subsection "**PLAN OPTIONS**" has been deleted in its entirety and replaced. This subsection now reads as follows:*

PLAN OPTIONS

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

- 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.

*On page 51, under the section "**MEDICAL BENEFITS—PLAN OPTIONS**", the subsection "**Preferred Provider Organization (PPO) Plan Option.**" has been deleted in its entirety.*

*On page 52, under the section "**MEDICAL BENEFITS—PLAN OPTIONS**", the subsection "**Qualified High Deductible Health Plan (QHDHP) Option.**" has been renamed and revised to support past and ongoing practice. This subsection now reads as follows:*

PPO High Deductible Health Plan (HDHP) Option. A qualified High Deductible Health Plan (HDHP) is a plan that satisfies certain regulatory/statutory requirements issued by the U.S. Department of Treasury with respect to minimum deductibles and maximum out-of-pocket expenses for both single and family coverage. A HDHP that is paired with an HSA must require Covered Persons to satisfy applicable deductible(s) before any benefits are provided for Eligible Expenses incurred, with very limited exceptions such as well child care and certain preventive care.

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

Important: Under a qualified High Deductible Health Plan (HDHP) (a plan which is paired with a Health Savings Account), Covered Persons must satisfy applicable deductible(s) before any benefits are provided for Eligible Expenses incurred (subject to limited exceptions as determined by federal law. Pursuant to Department of Treasury guidance: HDHPs are not permitted to apply the following toward satisfaction of required deductible(s):

- subsidies
- coupons
- rebates
- post-purchase reimbursements, and
- any other cost-sharing assistance provided to a Covered Person by any other entity(ies) including but not limited to the manufacturer.

The above list is represents examples and is not exhaustive.

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.

*On pages 57–74, under the section "**MEDICAL BENEFITS—ELIGIBLE EXPENSES**", as amended, all references to "**Preferred Provider Organization (PPO) Plan option**" have been deleted in their entireties.*

*On pages 57, under the section "**MEDICAL BENEFITS—ELIGIBLE EXPENSES**", as amended, a new subsection "**Acupuncture Treatment**" has been added. This new subsection reads as follows:*

Acupuncture Treatment

Expenses incurred for treatment and services related to acupuncture are considered Eligible Expenses. Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS" section. See also "Acupressure and hypnotherapy" in the "PLAN EXCLUSIONS" section.

*On page 75, under the section "**PREAUTHORIZATION**", as amended, the subsection "**Preauthorization for PPO Plan Option and Qualified High Deductible Health Plan Option.**" has been renamed. This subsection now reads as follows:*

- **Preauthorization for PPO 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.

*On pages 86–91, under the section "**PLAN EXCLUSIONS**", as amended, all references to "**Preferred Provider Organization (PPO) Plan option**" have been deleted in their entireties.*

*On page 86, under the section "**PLAN EXCLUSIONS**", as amended, the subsection "**Acupuncture, Acupressure and Hypnotherapy**" has been revised to remove the references to acupuncture. This subsection now reads as follows:*

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

*On page 93, under the section "**PRESCRIPTION DRUG BENEFITS—ELIGIBLE PRESCRIPTION DRUG EXPENSES**", as amended, a new item has been added. This item reads as follows:*

- **Epinephrine injectors:** Epinephrine injectors (e.g., EpiPen®) for Covered Persons age 18 or younger, when Medically Necessary.

*On page 128, at the end of the section, "**GENERAL PLAN ADMINISTRATION INFORMATION**" a new subsection "**COMPLIANCE WITH APPLICABLE LAW**" has been added for clarification purposes to support past and ongoing practice. This new subsection reads as follows:*

COMPLIANCE WITH APPLICABLE LAW

It is the intent of the Plan Sponsor that the Plan is compliant with all applicable laws, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("the ACA", or "Health Care Reform") and that such compliance occurs on the date applicable to the Plan. In the event the terms of the Plan are found to be deficient with regard to compliance with applicable law, the Plan shall be administered to comply with the minimum requirements of applicable law.

*After the section "**EXHIBIT 2: ENHANCED INFERTILITY SERVICES**", as amended, a new section "**EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)**" has been added to read as follows:*

EXHIBIT 3: PHARMACY DISCOUNT PROGRAM(S)

Amounts paid by a Covered Person will be applied to the deductible and out-of-pocket amounts, based on Plan provisions, when the Covered Person utilizes a Pharmacy discount program.

To receive the applicable deductible and out-of-pocket amount(s), Covered Persons must provide their receipts to the Plan Administrator. See the "GENERAL PLAN INFORMATION" section of this Plan for the Plan Administrator's contact information.

*Effective January 1, 2019: In the "**EXHIBIT 1: BE HEALTHY—USING YOUR PREVENTIVE CARE BENEFITS, EFFECTIVE 1/1/2019**" section, as amended, the subsection "**Men's Health**" has been revised to add the following important note to "**Vasectomy**" and "**Semen analysis post vasectomy**":*

> **IMPORTANT NOTE: The following applies to "Vasectomy" and "Semen analysis post vasectomy": For the HDHP option, the deductible must be met.** Covered Persons enrolled in a High Deductible Health Plan (HDHP) option, intended to be paired with a health savings account (HSA), must satisfy the Calendar Year deductible specified in the "SCHEDULE OF BENEFITS" section of the Plan, in order for these services to be covered at no cost sharing to the Covered Person. This limitation is designed to preserve the Covered Person's eligibility for certain federal tax benefits associated with HSAs under federal tax law.

IMPORTANT

Section 1557 of the 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: (800) 851-3379; members in Washington call: (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, (800) 368-1019 (TTY: (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 (800) 851-3379, WA Llame: (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 (800) 851-3379, WA: 呼叫 (877) 750-3515（TTY: 711）。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 851-3379, WA: Zadzwoń (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 (800) 851-3379, WA: Gọi (877) 750-3515 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 851-3379 IA, IL, IN, OH: 전화 WA: (877) 750-3515 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 851-3379, WA: Вызов (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 (800) 851-3379, WA: Tumawag (877) 750-3515 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 3379-851 (800)، ولاية واشنطن: اتصل بالرقم: 3515-750 (877) (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 (800) 851-3379, WA: Anruf (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 (800) 851-3379, WA: Appelez (877) 750-3515 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ (800) 851-3379, WA: કૉલ (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。(800) 851-3379 IA, IL, IN, OH: コール (877) 750-3515 WA: コール（TTY: 711）。

LET OP: Services Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик (800) 851-3379, WA: Виклик (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 (800) 851-3379, WA: Chiamare (877) 750-3515 (TTY: 711).