This document is an amendment to The Carle Foundation's January 1, 2022 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. If you need a copy of your PD/SPD, please contact your employer or plan sponsor. You may also contact customer service at the phone number on your Plan ID Card.

Notice: *If this information has been furnished to you electronically, you have a right to request and obtain a paper version of the information at no cost to you. To request a paper version, contact your employer, plan sponsor, or Human Resources Department at your place of employment who acts on behalf of the plan administrator. For more assistance, you may also contact customer service at the phone number on your Plan ID Card.*

Regarding:

1. **Services Requiring Preauthorization**
2. **PPO Plan Option—Schedule of Benefits**
3. **Preventive Care Services Benefit**
4. **Addendum: Be Healthy—Preventive Service Benefits**

AMENDMENT TO THE THE CARLE FOUNDATION EMPLOYEES' HEALTH AND DENTAL PLAN

The Plan grants the Employer the right to amend the provisions of the Plan. The Employer desires to make such amendment. Therefore, the Plan is amended as follows, with such amendment to be effective as of the dates specified herein.

AMENDMENT #1, effective January 1, 2023:

*On pages 9–10 of the section "**PREAUTHORIZATION**", the subsection "**SERVICES REQUIRING PREAUTHORIZATION**" has been revised and now reads as follows:*

SERVICES REQUIRING PREAUTHORIZATION

NOTE: Certain Prescription Drugs require Preauthorization. See the "PRESCRIPTION DRUG BENEFITS—PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" section for details.

NOTE: See the "ADDENDUM" COVID-19" section for information related to COVID-19 Preauthorization.

The Plan requires Preauthorization of the following Listed Services:

- Abdominoplasty/Panniculectomy
- Ambulance (non-urgent air)
- Bariatric surgery
- Blepharoplasty and eyebrow lift/brow ptosis
- Breast reconstruction surgeries:
  - breast implant surgeries
  - gynecomastia surgery
  - reduction mammoplasty
- Cardiac imaging and procedures

  - ECHO
  - ECHO stress
  - cardiac rhythm implantable devices
  - myocardial perfusion imaging
  - nuclear medicine
  - diagnostic heart catheterization
- Chiropractic and massage therapy (NOTE: If services are subject to a dollar or visit benefit limitation, Preauthorization is not required. See the "SCHEDULE OF BENEFITS" section.)
- Clinical trials—Phase I, II, III and IV
- Cosmetic and reconstructive surgery
- Dental services (if done in a facility rather than in a Provider's office)
- Durable Medical Equipment—select
- Electrical stimulation for gastroparesis
- Endothelial keratoplasty
- Experimental and investigational services
- Gender affirmation procedures
- Genetic testing (including molecular diagnostics)—select (NOTE: The following prenatal genetic testing CPT codes do not require Preauthorization: 81420 and 81507.) (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org.)
- Hyperbaric oxygen therapy
- Imaging:
  - CT
  - CTA
  - MRI
  - MRA
  - PET
  - 3D (3D mammography does not require Preauthorization)
- Infertility services (all diagnostic tests, medications, treatments, etc.)
- Implantable nerve stimulators—select (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org.)
- Inpatient admission to an acute care Hospital or facility—*notification to the Utilization Review Manager is required upon admission*
- Interventional pain management
- Joint surgery—select (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org)
- Laser treatment of psoriasis
- Oncology Pathways (inpatient chemotherapy does not require Preauthorization)
- Out-of-network referral for HMO
- Port wine stain removal
- Post-Acute Care admission (Skilled Care Facility, Inpatient Rehab Facility, Long-term Acute Care)
- Radiation therapy, including but not limited to the following:
  - proton beam therapy
  - stereotactic radiosurgery
- Rehabilitative therapies:
  - occupational therapy
  - physical therapy
  - speech therapy

- Select surgical procedures requiring an elective inpatient stay may require Preauthorization (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org)
- Sleep diagnostics, evaluations and supplies
- Specialty Pharmacy (including home infusion drugs)—select (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org)
- Spine surgery—select (NOTE: To verify specific CPT/HCPCS codes that require Preauthorization, Covered Persons may contact customer service at the phone number on the Plan ID Card and Providers may visit HealthAlliance.org)
- Transcranial magnetic stimulation (TMS) treatment
- Transplant services
- Uvulopalatopharyngoplasty (UPPP)
- Vision therapy

Additional required notification(s):

- **Emergency Admission Notification:** If the Covered Person receives treatment on inpatient basis for an Emergency Medical Condition, they, or someone acting on their behalf, or the Hospital, or the attending Physician, must notify the Utilization Review Manager **within 48 hours** of admission, or as soon as possible, after care begins. (notification required; no review)

PREAUTHORIZATION PENALTY

For details about when and how the Plan's Preauthorization penalty applies, see the subsections "PREAUTHORIZATION FOR COVERED PERSONS RESIDING WITHIN 35 MILES OF THE FOLLOWING ZIP CODES: 61801, 61761, 61530, 62450, 60942, OR 28374" and "PREAUTHORIZATION FOR COVERED PERSONS RESIDING OUTSIDE 35 MILES OF THE FOLLOWING ZIP CODES: 61801, 61761, 61530, 62450, 60942, OR 28374" above. See also "PREAUTHORIZATION PENALTY" in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

*On pages 14–21 of the section "**PREFERRED PROVIDER OPTION (PPO) PLAN—SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, PLAN: PPO PLAN OPTION**" the "**Diagnostic testing**" benefit has been revised to read as "Outpatient lab services", "Outpatient radiology services", and "Outpatient advanced radiology services". This section now reads as shown on the next several pages:*

SCHEDULE OF BENEFITS
MEDICAL AND PRESCRIPTION DRUG BENEFITS
PLAN: PPO PLAN OPTION

MAXIMUM BENEFITS	Your Maximum Benefits when using Preferred Providers and/or Non-Preferred Providers (combined)
Individual Maximum Benefit	Unlimited per Covered Person, per Lifetime, except as otherwise specified
Inpatient rehabilitation and Skilled Nursing Care (combined)	120 days per Covered Person, per Benefit Period
Chiropractic services [1]	$750 per Covered Person, per Benefit Period
Home health care	100 visits per Covered Person, per Benefit Period
Infertility services (*enhanced* Infertility services) [1]	$25,000 per Covered Person, per Lifetime
Outpatient rehabilitative therapy services (occupational, physical and speech therapies)	60 visits (all therapies combined) per Covered Person, per Benefit Period
Temporomandibular joint (TMJ) disorder treatment [1]	$5,000 per Covered Person, per Lifetime
Tobacco cessation products	One product per 12-month period, per Covered Person
Tobacco cessation programs	One program in a 12-month period per Covered Person, and further limited to three programs per Covered Person, per Lifetime

BENEFIT PERIOD DEDUCTIBLES	Your Deductible responsibility when using Preferred Providers	Your Deductible responsibility when using Non-Preferred Providers
Single coverage	$1,000	$2,000
Family Unit coverage	$3,000	$6,000

Deductibles apply to all services/benefits, if determined to be Eligible Expenses, except the following:

- Prescription Drugs and Specialty Prescription Drugs; and
- the following when provided by a Preferred Provider:
  - office visits;
  - virtual visits;
  - preventive care services [4];
  - diagnostic testing—Outpatient lab services;
  - diagnostic testing—Outpatient radiology services;
  - diagnostic testing—Outpatient advanced radiology services; and
  - routine eye exams.

For Family Unit coverage: If either two or three family members are enrolled in the Plan, each family member must satisfy the single Deductible. If four or more family members are enrolled, any combination of family members can satisfy the Family Unit Deductible. No one family member will exceed the single Deductible amount.

The Preferred Provider and Non-Preferred Provider Deductibles are calculated separately. A new Deductible will apply each Benefit Period.

BENEFIT PERIOD OUT-OF-POCKET MAXIMUMS	Your Out-of-Pocket Maximum responsibility when using Preferred Providers	Your Out-of-Pocket Maximum responsibility when using Non-Preferred Providers
Single coverage	$4,000	$25,000
Family Unit coverage	$12,000	$75,000

All medical and Prescription Drug expenses, including Copayments, Coinsurance and Deductibles, apply to the Out-of-Pocket Maximums, except the following:

- expenses that exceed the Maximum Allowable Charge;
- balance-billed charges; and
- expenses that are otherwise considered excluded expenses.

The Preferred Provider and Non-Preferred Provider Out-of-Pocket Maximums are calculated separately.

For Family Unit coverage: If either two or three family members are enrolled in the Plan, each family member must satisfy the single Out-of-Pocket Maximum. If four or more family members are enrolled, any combination of family members can satisfy the Family Unit Benefit Out-of-Pocket Maximum. No one family member will exceed the single Out-of-Pocket Maximum amount.

PREAUTHORIZATION PENALTY	Your penalty responsibility when using Preferred Providers	Your Preauthorization penalty responsibility when using Extended Network Providers and/or Non-Preferred Providers
Failure to obtain Preauthorization	$0	See the "PREAUTHORIZATION—PREAUTHORIZATION PENALTY" section.

See the "PREAUTHORIZATION" section for **important details** regarding required notification and Preauthorization responsibilities.

The Listed Services specified in the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section require Preauthorization *in advance* of receiving the services, supplies or treatment, regardless of the Provider type (e.g., Preferred Provider, Extended Network Provider, Non-Preferred Provider).

TYPE OF MEDICAL EXPENSE	You Pay Preferred Providers	You Pay Non-Preferred Providers
Inpatient Services/Benefits		
Physician services	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Hospice care	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Hospital care (includes services, supplies, Prescription Drugs and Specialty Prescription Drugs)	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Mental Health Disorder/ Substance Use Disorder services and treatment [6]	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible

TYPE OF MEDICAL EXPENSE	You Pay Preferred Providers	You Pay Non-Preferred Providers
Human organ transplant services (**Note:** All transplants must be performed at a facility approved by the Plan Administrator or its designee.)	20% Coinsurance, after Deductible	*Not considered an Eligible Expense*
Rehabilitation and Skilled Nursing Care (combined) [2]	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Outpatient Services/Benefits		
Office visit—primary care	$20 Copayment per visit Deductible waived	50% Coinsurance, after Deductible
Office visit—specialty care	$40 Copayment per visit Deductible waived	50% Coinsurance, after Deductible
Office visit—Mental Health Disorder/Substance Use Disorder services and treatment [6]	$20 Copayment per visit Deductible waived	50% Coinsurance, after Deductible
Routine eye exams	$40 Copayment per exam Deductible waived	50% Coinsurance, after Deductible
Telehealth services **Note:** For benefit details relating to COVID-19, see the "ADDENDUM: COVID-19" section.	Primary care or Specialty care office visit benefit level applies	50% Coinsurance, after Deductible
Virtual visits	Visits 1–3: $0 Copayment per visit, Deductible waived Visits 4 and over: $20 Copayment per visit, Deductible waived	*Not considered an Eligible Expense*
Routine prenatal care visit [5]	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Ambulance services [3]	$200 Copayment, Deductible, then 20% Coinsurance	$200 Copayment, Deductible, then 20% Coinsurance (Preferred Provider benefit level applies)
Emergency Services [3]	Visits 1–2: $200 Copayment, Deductible, then 20% Coinsurance, per Covered Person per visit Visits 3 and over: $500 Copayment, Deductible, then 20% Coinsurance per Covered Person per visit	Visits 1–2: $200 Copayment, Deductible, then 20% Coinsurance, per Covered Person per visit Visits 3 and over: $500 Copayment, Deductible, then 20% Coinsurance per Covered Person per visit (Preferred Provider benefit level applies for all visits)
Urgent Care facility	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible (Preferred Provider benefit level applies)
Preventive care services [4]	0% Coinsurance Deductible waived	50% Coinsurance, after Deductible

TYPE OF MEDICAL EXPENSE	You Pay Preferred Providers	You Pay Non-Preferred Providers
Additional surgical opinion	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Diagnostic testing [7]—Outpatient lab services	$50 Copayment Deductible waived	50% Coinsurance, after Deductible
Diagnostic testing [7]—Outpatient radiology services	$100 Copayment Deductible waived	50% Coinsurance, after Deductible
Diagnostic testing [7]—Outpatient advanced radiology services (CT scan, PET scan, MRI)	$250 Copayment Deductible waived	50% Coinsurance, after Deductible
Home health care [2]/home infusion	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Hospice care	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Mental Health Disorder/Substance Use Disorder services and treatment—all Outpatient services [6] (except office visits)	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Oral surgery (includes surgical tooth extractions)	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Outpatient Surgery/procedures	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Rehabilitative therapy services (occupational, physical and speech therapies) [2]	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Other Services/Benefits		
Chiropractic services [1, 2]	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible (Preferred Provider benefit level applies)
Durable Medical Equipment and orthopedic appliances (including but not limited to prostheses and orthotics)	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Infertility services (*enhanced* Infertility services) [1, 2]	50% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Outpatient Specialty Prescription Drugs provided under the medical benefit	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Temporomandibular joint (TMJ) disorder treatment [1, 2]	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible
Other expenses described in the Plan, and not otherwise addressed in this Schedule of Benefits, if determined to be Eligible Expenses	20% Coinsurance, after Deductible	50% Coinsurance, after Deductible

Footnote descriptions for MEDICAL BENEFITS:

[1] Non-essential health benefits may be subject to a separate benefit maximum amount as noted herein.

[2] See the "MAXIMUM BENEFITS" subsection of this "SCHEDULE OF BENEFITS" section for benefit limitations.

[3] The following applies for Plan Years beginning prior to January 1, 2022: Notwithstanding anything in the Plan to the contrary, the method used to determine the Eligible Expense for Emergency Services will be equal to the greatest of the following three possible amounts:

- The median amount negotiated with Preferred Providers for Emergency Services provided; or
- The amount for the Emergency Service calculated using the same method the Plan generally uses to determine payments for Non-Preferred Provider services, but substituting the Preferred Provider level for the Non-Preferred Provider benefit level; or
- The amount that would be paid under Medicare Part A and Part B for the Emergency Service excluding any Preferred Provider Deductible, Copayment or Coinsurance, if applicable.

The following applies for Plan Years beginning on or after January 1, 2022: See also "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES" at the end of the "MEDICAL BENEFITS" section.

[4] Preventive care services include but are not limited to annual and routine physicals, well-child care, injections, immunizations, mammograms, Pap smears, colorectal screenings and cholesterol screenings. Age and frequency schedules apply. For detailed information, see "Preventive care services" in the "MEDICAL BENEFITS—BENEFITS" section and the "ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS" section.

[5] Routine prenatal care services provided by a Preferred Provider that are considered preventive care services are subject to the Preferred Provider preventive care services benefit level.

[6] The following applies to Covered Persons who reside within 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374: Covered Persons are not limited to utilizing only Mental Health/Substance Use Disorder Providers within the Carle Health & Affiliated Providers Network. A Covered Person who chooses to use the Health Alliance Network for Mental Health Disorder/Substance Use Disorders services and treatment is **not required** to obtain Preauthorization for the *use of the Health Alliance Network Provider*.

[7] The Copayment amounts do not apply to services performed on an inpatient basis, in an observation setting, in ambulatory settings, or in an Emergency room.

For diagnostic testing benefit details relating to COVID-19, see the "ADDENDUM: COVID-19" section.

TYPE OF PRESCRIPTION DRUG EXPENSE	**You Pay* Preferred Pharmacy**	**You Pay* Non-Preferred Pharmacy**
Retail and Specialty Prescription Drugs [1, 2] • mandatory generic substitution • limited to a maximum 30-day supply • includes retail and Specialty Infertility prescriptions • Deductible is waived on each tier level • Preauthorization is required for Specialty Prescription Drugs	**Tier 1 (Preferred generic):** $0 Copayment per script **Tier 2 (Non-Preferred generic):** $10 Copayment per script **Tier 3 (Preferred brand):** $40 Copayment per script **Tier 4 (Non-Preferred brand):** $60 Copayment per script **Tier 5 (Preferred Specialty):** 30% Coinsurance per script **Tier 6 (Non-Preferred Specialty):** 30% Coinsurance per script	*Not considered an Eligible Expense*

TYPE OF PRESCRIPTION DRUG EXPENSE	You Pay* Preferred Pharmacy	You Pay* Non-Preferred Pharmacy
Retail 90 program at retail Pharmacies [1, 2] • mandatory generic substitution • limited to a maximum 90-day supply • includes Specialty Infertility prescriptions • Deductible is waived on each tier level • Preauthorization is required for Specialty Prescription Drugs	**Tier 1 (Preferred generic):** $0 Copayment per script **Tier 2 (Non-Preferred generic):** $27.50 Copayment per script **Tier 3 (Preferred brand):** $110 Copayment per script **Tier 4 (Non-Preferred brand):** $165 Copayment per script	*Not considered an Eligible Expense*
Mail-order Prescription Drugs [1, 2] • mandatory generic substitution • limited to a maximum 90-day supply • includes Specialty Infertility prescriptions • Deductible is waived on each tier level • Preauthorization is required for Specialty Prescription Drugs	**Tier 1 (Preferred generic):** $0 Copayment per script **Tier 2 (Non-Preferred generic):** $27.50 Copayment per script **Tier 3 (Preferred brand):** $110 Copayment per script **Tier 4 (Non-Preferred brand):** $165 Copayment per script	*Not considered an Eligible Expense*
Retail tobacco cessation drugs (when enrolled in the Quit for Life® program) [1, 3]	$15 Copayment per script Deductible waived	*Not considered an Eligible Expense*
Prescription Pharmacy Contraceptives [1, 4] (e.g., oral Contraceptives, patches, ring) • limited to one Contraceptive product per month • Deductible is waived on each tier level	**Tier 1 (Preferred generic):** $0 Copayment per product **Tier 2 (Non-Preferred generic):** $10 Copayment per product **Tier 3 (Preferred brand):** $40 Copayment per product **Tier 4 (Non-Preferred brand):** $60 Copayment per product	*Not considered an Eligible Expense*
FDA-approved, over-the-counter (OTC) Contraceptive products [5] (limited to one Contraceptive product per month)	$0 Copayment per product Deductible waived	*Not considered an Eligible Expense*

Footnote descriptions for PRESCRIPTION DRUG BENEFITS:

*** Note:** For plans effective or renewing on or after January 1, 2021, a Covered Person's Deductible, Copayment and Coinsurance amounts (cost sharing) for prescription insulin drugs will not exceed $100 for a 30-day supply. For plans effective or renewing on or after January 1, 2022 and each subsequent January 1, the limit on the cost-sharing shall increase by a percentage equal to the percentage change from the preceding year in the medical care component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor.

[1] Retail and Specialty Pharmacy Prescription Drugs may be prescribed by a Non-Preferred Pharmacy but must be dispensed according to the terms specified in the "PRESCRIPTION DRUG BENEFITS" section. The Copayment or Coinsurance is based on the drug or classes of drugs prescribed.

[2] Specialty Prescription Drugs are administered through Carle Specialty Pharmacy. For questions or assistance with obtaining Specialty Prescription Drugs, contact Carle Specialty Pharmacy at (217) 383-8700, 8 a.m. to 5 p.m. weekdays.

[3] Nicotine Replacement Therapy (NRT) purchased through the Quit for Life® mail-order program is not subject to the Copayment.

[4] 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.

[5] FDA-approved, over-the-counter (OTC) Contraceptives, including but not limited to condoms, sponges and spermicide, require a prescription from a Physician.

For detailed information pertaining to retail Prescription Drugs and Specialty Prescription Drugs, see the "PRESCRIPTION DRUG BENEFITS" section.

PLEASE NOTE:

- The following applies for Play Years beginning on or after January 1, 2022: Benefit claims that are determined to meet requirements to be considered surprise medical bills may be subject to certain protections. See "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES" at the end of the "MEDICAL BENEFITS" section.
- A Covered Person's cost sharing, if any, for a Preferred Provider, may be based on the allowed/discounted/ negotiated/contract amount, and not the billed amount. A Provider may bill for any amount up to the allowed/discounted/negotiated/contract amount after the Plan has paid benefits applicable to the expenses incurred.
- A Covered Person's cost sharing, if any, for a Non-Preferred Provider, is generally based on the Maximum Allowable Charge. In addition to the Deductible, Copayment, and/or Coinsurance, and other cost sharing amounts, if applicable, the Covered Person also pays expenses incurred in excess of the Maximum Allowable Charge. A Provider may bill for any amount up to the billed amount after the Plan has paid benefits applicable to the expenses incurred.
- A Covered Person's cost sharing for expenses incurred in excess of the limitations stated in the Plan may be subject to Deductibles, Copayments and/or Coinsurance specified in this "SCHEDULE OF BENEFITS" section, or may not be determined as Eligible Expenses at all. A Provider may bill for any amount up to the billed amount after the Plan has paid benefits applicable to the expenses incurred.
- Services, supplies or treatments provided by a Non-Preferred Physician or at a Non-Preferred Provider facility, if determined to be Eligible Expenses, may be reimbursed at the applicable Preferred Provider benefit level under the following circumstance(s):
    - If a Non-Preferred Provider is used during a Medical Emergency, benefits may be payable at the Preferred Provider benefit level (Preauthorization is not required). See "Ambulance services" and "Emergency Services" in the "TYPE OF MEDICAL EXPENSE" table above.

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*On page 57 of the section "**MEDICAL BENEFITS—BENEFITS**", the subsection "**Colorectal cancer screening**" has been revised and now reads as follows:*

- **Colorectal cancer screening:** included under the preventive care services benefit.
    - Outpatient Surgery Copayments or Coinsurance apply when procedures are performed in an Outpatient setting for which there is an associated facility fee.
    - Routine procedures performed in an Outpatient setting for which there is an associated facility fee are subject to the Copayments and Coinsurance listed in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
    - If polyps are removed when procedures are performed in an Outpatient setting for which there is an associated facility fee, the Outpatient surgery Copayments and Coinsurance apply (see the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section).
    - See "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.

*On page 57 of the section "**MEDICAL BENEFITS—BENEFITS**", the subsection "**Contraceptive methods, procedures and services**" has been revised and now reads as follows:*

- **Contraceptive methods, procedures and services:** When prescribed or used for preventive care purposes, included under the preventive care services benefit.
  - See "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.
  - Prescription Contraceptives, including but not limited to oral Contraceptives, patches or the ring, are not included under the "MEDICAL BENEFITS—BENEFITS" section. See the "PRESCRIPTION DRUG BENEFITS" section for details.

*On pages 61–62 of the section "**MEDICAL BENEFITS—BENEFITS**", the subsection "**Maternity care**" has been revised and now reads as follows:*

- **Maternity care:**
  - The maternity care benefit applies to all Covered Persons which includes all Dependent (defined).
  - Routine prenatal care, delivery and postnatal care.
  - Prenatal visits that are not considered routine are subject to a separate specialty office visit Copayment and/or Coinsurance.
  - A minimum length of inpatient stay of 48 hours following a vaginal delivery and 96 hours following a delivery by Caesarean section for the Covered Person and the newborn. The Covered Person's Physician may determine after consultation with the person who gave birth that a shorter length of stay is appropriate. This determination must be made in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Upon evaluation and the recommendation of a Physician, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.
  - See also "Newborn care" and "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section for other maternity- and newborn-related services and items.

*On pages 64–65 of the section "**MEDICAL BENEFITS—BENEFITS**", the subsection "**Preventive care services**" has been revised and now reads as follows:*

- **Preventive care services:** NOTE: In general, benefits for newly recommended preventive care services must be made effective no later than the first day of the first Plan Year that begins one year after the recommendation or guideline is issued. This means that there is generally an interval of at least 365 days between the date on which a recommendation or guideline is issued and the date on which the Plan must provide benefits for the services listed in that recommendation or guideline. For information about effective dates for specific benefits under this Plan, contact the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.
  - Preventive care services when provided on an Outpatient basis that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following:
    - Evidence-based items or services with an "A" or "B" rating recommended by the United States Preventive Services Task Force (USPSTF);
    - Immunizations for routine use for children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
    - Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
    - Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA for women.

    The benefits available meet at least the minimum requirements of applicable law. For more information,

visit https://healthcare.gov/preventive-care-benefits/. Recommendations and guidelines may be updated periodically based on changes made by the source agency or organization.

- For a list of common preventive care services and associated procedure codes, see the "ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS" section.
- No cost sharing is required by the Covered Person when the services are obtained from Preferred Providers.
- Cost-sharing is required by the Covered Person for the office visit expense when preventive care services are billed separately or are not the primary purpose of an office visit.
- Colonoscopy following a positive fecal occult blood test including FIT (fecal immunochemical test) or at-home DNA stool test (e.g., Cologuard) is considered under the preventive care services benefit.
- The following applies to colorectal cancer screenings:
  - Outpatient Surgery Copayments or Coinsurance apply when procedures are performed in an Outpatient setting for which there is an associated facility fee.
  - Routine procedures performed in an Outpatient setting for which there is an associated facility fee are subject to the Copayments and Coinsurance listed in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - If polyps are removed when procedures are performed in an Outpatient setting for which there is an associated facility fee, the Outpatient surgery Copayments and Coinsurance apply (see the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section).
- Laboratory and X-ray services provided in diagnosing and treating a medical condition are considered under the diagnostic testing benefit.
- Additional preventive care expenses/screenings/tests/visits are subject to the applicable Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
- If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive care service, then the Plan may use reasonable medical management techniques to determine any such benefit limitations.
- When the Plan does not have a Provider who can provide a specific eligible preventive care service in its Preferred Provider network, the Plan will consider a service provided by a Non-Preferred Provider without imposing any cost sharing requirement on the Covered Person for that specific service. To determine if this applies to a specific situation, contact the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.
- The information provided above is accurate at the time of issue. For questions, contact the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.
- See also "Sterilization procedures" in this "MEDICAL BENEFITS—BENEFITS" section.

*The section "**ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS**" has been revised and now reads as follows:*

ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS

See the following pages that describe some of your preventive service benefits.

2023 Be Healthy
Preventive service benefits made for you.

Effective January 1, 2023

Your health matters most.

Your plan covers preventive services and tests even when you're healthy. Here's a partial list of the services included in your comprehensive preventive service benefit.*

- One preventive service exam per Covered Person (no age limitations) per plan year.
- At least one preventive visit to a Woman's Principal Healthcare Provider per plan year, subject to reasonable medical management.
- Well-child care.
- The screenings, procedures and immunizations listed below, within the applicable preventive service benefit:
    - Blood sugar screening.
    - Cervical cancer screening (Pap smear).
    - Cervical cancer vaccine.
    - Childhood immunizations.
    - Chlamydia screening.
    - Cholesterol screening.
    - Colorectal cancer screening (flexible sigmoidoscopy, screening colonoscopy, fecal occult blood test, including FIT).

NOTE: Benefits listed are accurate at the time of print. Additional information is available by logging into hally.com. For complete information about all the preventive benefits available to you, please see your Plan Document/Summary Plan Description or call us at the phone number on the back of your health plan ID card.

*Office visit copayment and/or coinsurance may apply.

A detailed listing of preventive service-covered procedures and services follows.

Procedure Codes	Descriptions
Immunizations	
90460–90461, 90471–90474	Immunization administration
90632–90634	Hepatitis A
90636	HepA-HepB adult
90619, 90644, 90733–90734	Meningococcal
90620–90621	MenB
90647–90648	Hib
90649 90650–90651	HPV quadrivalent 3 dose ages 9–26 HPV bivalent 3 dose ages 9–26
90630, 90653–90658, 90660–90662, 90664, 90666–90668, 90672, 90673, 90674, 90682, 90685–90689, 90694, 90756, Q2034–Q2039	Influenza
90670, 90732	Pneumococcal
90680–90681	Rotavirus
90696	DTaP-IPV ages 4–6
90697	DTap-IPV-Hib-HepB
90698	DTaP-Hib-IPV
90700	DTaP < 7 years
90702	DT < 7 years
90707	Measles, mumps and rubella (MMR)
90710	Measles, mumps, rubella and varicella vaccine (MMRV)
90713	Poliovirus (IPV)
90714	Td 7 years and older
90715	Tdap 7 years and older
90716	Varicella (VZV) – chicken pox
90723	DTaP-HepB-IPV
90750	Herpes Zoster (shingles) ages 50 and older
90739, 90740, 90743, 90744, 90746, 90747	Hepatitis B
90748	HepB-Hib
90759	Hepatitis B (Recombinant)
G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis B vaccine
Alcohol Screenings	
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention (SBI) services; 15 to 30 minutes)
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST and brief intervention (SBI) services; greater than 30 minutes)
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Osteoporosis Screening		
76977, 77080, 77081, G0130	DXA, bone density study	
Cholesterol		
80061	Lipid profile	Once every 5 years ages 20 and older, and children at high risk
82465	Cholesterol, serum or whole blood, total	Once every 5 years ages 20 and older, and children at high risk
83718	Lipoprotein, direct measurement; high-density cholesterol (HDL cholesterol)	Once every 5 years ages 20 and older, and children at high risk
83721	Lipoprotein, direct measurement; LDL cholesterol	Once every 5 years ages 20 and older, and children at high risk
84478	Triglycerides	Once every 5 years ages 20 and older, and children at high risk
Colorectal Cancer Screening All colorectal cancer screening tests require submission of a diagnosis code (Z12.10, Z12.11, Z12.12, or Z12.80) as determined appropriate for your situation, by your physician.		
G0104, G0106, 45330, 45331, 45338	Sigmoidoscopy	Once every 5 years ages 45–75
G0105, G0120, G0121, 45378, 45380, 45384, 45385, 45388	Colonoscopy	Once every 10 years ages 45–75
74263	Virtual colonoscopy	Once every 5 years ages 45–75. Requires health plan prior authorization
G0328, 82270, 82274	Fecal immunochemical test (FIT) and FecalOccult Blood Tests (FOBT), includingimmunoassay	Annually starting at age 45
81528	At-home DNA stool test	Once every 3 years ages 45-75
Diabetes		
82947, 82950–82951	Abnormal blood glucose and Type 2 Diabetes Mellitus screening	
83036	Hemoglobin A1C	With diagnosis code Z00.00, Z00.01 or Z13.1
HIV		
86689	Antibody, HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	Annually
86703	Antibody, HIV-1 and HIV-2, single assay	Annually
87389	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA],enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	Annually
87806	HIV-1 antigen with HIV-1 HIV-2 antibodies	Annually
G0432, G0433, G0435	Infection agent antibody detection	Annually
G0475	HIV antigen/antibody, combination assay, screening	Annually
Services Related to HIV Pre-Exposure Prophylaxis (PrEP) Medication - Member must not be HIV infected to start PrEP therapy		
80081, 86689, 86701- 86703, 87389-87391,87534-87539, 87806, G0432, G0433, G0435, G0475, S3645	HIV testing	Test prior to start of PrEP therapy, and then once every three months. With diagnosis code Z20.2 or Z20.6

36415	Venipuncture	With diagnosis code Z20.2 or Z20.6
81596, 86803, 87516, 87517, 87340, 87341, 87350, 87380, 87520-87522, 87901, 87902, 87906, 87910, 87912, G0472, G0499	Hepatitis B and C testing	Test prior to starting PrEP therapy, and then periodically monitor - in particular after PrEP is concluded - to ensure liver function returns to normal. With diagnosis code Z20.2 or Z20.6
82565, 82570, 82575, 0602T, 0603T	Creatinine testing	With diagnosis code Z20.2 or Z20.6
81025, 84702, 84703	Pregnancy testing	Test before beginning PrEP therapy and during therapy. With diagnosis code Z20.2 or Z20.6
0065U, 0210U, 86592, 86593, 86631, 86632, 86780, 87110, 87164, 87166, 87270, 87285, 87320, 87485-87487, 87490-87492, 87590-87592, 87810, 87850	Sexually Transmitted Infection Screening	Test for a baseline, and periodically thereafter while on PrEP. With diagnosis code Z20.2 or Z20.6
G0445, 99401-99404, 99411, 99412	Adherence counseling to ensure adherence to the prescribed medication and to maximize PrEP's effectiveness	With diagnosis code Z20.2 or Z20.6
Men's Health		
76706	Ultrasound AAA screening	One per lifetime for men ages 65–75
Newborn		
84030	Phenylalanine (PKU)	Ages 0–28 days
84437, 84443	Congenital hypothyroidism screening	Ages 0–90 days
85660	Sickle cell screening	
85014, 85018	Anemia test	Age 21 and younger. With diagnosis code Z00.121–Z00.129
83655	Lead screening	Age 0-6 years for children who are at risk for exposure. With diagnosis code Z00.121–Z00.129
80061, 82465, 83721, 84478	Dyslipidemia screening	Age 21 and younger. With diagnosis code Z00.121–Z00.129, Z13.220
S3620	Newborn metabolic screening panel	
Sexually Transmitted Diseases		
G0445	Intensive behavioral counseling to prevent STIs. Includes education, skills training and guidance on how to change sexual behavior	Annually
86592–86593	Syphilis test	Annually. With diagnosis code Z00.00, Z00.01, Z00.121, Z00.129, Z11.3, or Z20.2
87270, 87320, 87490–87492, 87810	Chlamydia	Annually for women age 24 and younger, and in older women at increased risk for infection (with diagnosis code Z11.3)
87850, 87590–87592	Gonorrhea	Annually for women age 24 and younger, and in older women at increased risk for infection (with diagnosis code Z11.3)
87623–87625, G0476	Papillomavirus (HPV)	Screening should begin at 30 years of age and should occur no more frequently than every five years.
Women's Health		
P3000–P3001, Q0091	Pap smear	Every three years for women ages 21–65
G0101	Cervical or vaginal cancer screening, pelvic and breast exam	

G0123, G0124, G0141, G0143–G0145, G0147– G0148	Screening cytopathology, cervical or vaginal	Every three years for women ages 21–65
88141–88143, 88147, 88148, 88150, 88152–88155, 88164–88167, 88174–88175	Cytopathology, cervical or vaginal	Every three years for women ages 21–65
S9443	Lactation classes (breast feeding support and counseling)	
E0602, E0603	Breast pump, double electric, manual	Including but not limited to, one per pregnancy, subject to reasonable medical management.
Women's Health – Contraceptive Management* (with diagnosis)		
A4261	Cervical cap for contraceptive use	
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	
A4266	Diaphragm for contraceptive use	
A4267	Contraceptive supply, condom, male	Must be paid at the pharmacy counter with a prescription from a physician to obtain the preventive service benefit.
A4268	Contraceptive supply, condom, female	Must be paid at the pharmacy counter with a prescription from a physician to obtain the preventive service benefit.
S4989, J7296–J7298, J7301	Contraceptive intrauterine device (IUD), including implants and supplies	
J7307	Contraceptive non-biodegradable drug implant and supplies	
J1050, 96372	Medroxyprogesterone acetate and administration	
11982, 11983	Insertion and removal of non-biodegradable implant	
57170	Diaphragm or cervical cap fitting with instructions	
58300, 58301	Insertion and removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600, 58605, 58611	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip or Falope ring)	
Women's Health - Breast Cancer Screening		
77063, 77067	Screening mammography	Once per year ages 35 and up
96040	Medical genetics risk assessment and counseling (for BRCA)	For women with a family or personal history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations. With diagnosis code(s) Z80.3, Z85.3, Z80.41, Z57.01, Z57.02, Z85.43, Z85.44, Z85.89, Z15.01
Women's Health – Obstetric Exams and Screening (with maternity diagnosis)		
80055, 80081	Obstetric profile	
81000–81002	Urinalysis	
82950–82951	Gestational Diabetes Mellitus screening	
83540	Iron	
85007, 85009	Differential WBC count	
85025, 85027	Automated hemogram	
86762	Antibody, rubella	

86850, 86900–86901	Rh(D) Incompatibility screening	
87086, 87088	Urine culture/colony count; urine bacteria	
87340–87341	Hepatitis B surface antigen detection	
85004	Blood count; automated differential WBC	
Smoking Cessation		
99406, 99407	Smoking and tobacco use cessation counseling visit	
Miscellaneous		
86480–86481, 86580	Tuberculosis (TB) screening	For adults and children at higher risk of tuberculosis with diagnosis code Z00.00, Z00.129, or Z11.1
92551	Hearing screening, pure tone	Age 21 and younger
G0444	Annual depression screening; 15 minutes	
96127	Behavioral assessment	
G0446	Annual face-to-face intensive behavioral therapy to reduce CVD risk; 15 minutes	
G0447	Face-to-face behavioral counseling for obesity, individual, 15 minutes	Annually for adults and children ages 6 and older
G0473	Face-to-face behavioral counseling for obesity, group (2–10 people), 30 minutes	Annually for adults and children ages 6 and older
G0499	Hepatitis B screening	
G0472, 86803	Hepatitis C screening	Annually ages 18-79
99173	Vision screening test	Age 21 and younger
96160	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	
96110	Developmental testing	
99188	Application of fluoride varnish	Ages 0-6
G0296	Visit to determine low dose CT eligibility	With diagnosis code Z87.891
71271	Low dose CT for lung cancer screening	Annually ages 50–80 for Covered Persons with a 20 pack-year smoking history and currently smoke or who have quit within the past 15 years
99473–99474	Screening for high blood pressure – includes obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment	Adults age 18 and older with diagnosis code R03.0
Preventive Care Exams		
99381–99387, 99391–99397	Preventive medicine services	
99401–99404, 99411, 99412	Preventive counseling	

If you have any questions about your preventive service benefit, please call the number on the back of your health plan ID card, Monday through Friday, 8 a.m. – 5 p.m.

*For Covered Persons with pharmacy benefits, a listing of preventive drugs covered at the pharmacy, including contraceptives, can be found at HealthAlliance.org.

NOTICE

This 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.

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