SUMMARY PLAN DESCRIPTION

# The Carle Foundation Employees' Health and Dental Plan

**Summary Plan Description and Plan Document**

January 1, 2022 PD/SPD

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# GENERAL PLAN INFORMATION

This section provides details about the Plan, including pertinent addresses and phone numbers relative to the administration of the Plan.

## WRITTEN PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This document serves as both the written Plan document ("PD") and the Summary Plan Description ("SPD"). It is very important that each Covered Person review this document carefully to confirm a complete understanding of the benefits and coverage available, as well as their responsibilities, under the Plan.

This document consists of several sections, all of which work together. The "MEDICAL BENEFITS" section provides an overview of the benefit provisions of the Plan and can provide a general outline of the benefits that are available. However, **it is important to read the entire document**, including the "DEFINED TERMS" section, to fully understand the Plan's benefits and coverage.

## TYPE OF ADMINISTRATION

The Plan is self-funded and the administration is provided through a Third Party Administrator. The funding for the benefits is derived from the general assets of the Employer and amounts paid by Covered Persons who are required to make contributions towards the cost of their coverage. The Plan is not insured.

## PLAN NAME

The Carle Foundation Employees' Health and Dental Plan

**PLAN NUMBER:** 504

**TAX ID NUMBER:** 37-0673465

## TYPE OF PLAN

A self-funded group health benefit plan providing medical, prescription drug and dental benefits.

**PLAN EFFECTIVE DATE:** July 1, 1979

**PLAN RESTATEMENT DATE:** January 1, 2022

**PLAN YEAR:** January 1 through December 31

**BENEFIT PERIOD:** January 1 through December 31

**ERISA APPLICABILITY TO THE PLAN:** ERISA applies.

## GOVERNING LAW

The interpretation of the terms and provisions of the Plan shall be governed by the laws of the State of Illinois where it has been executed, except where preempted by federal law.

## EMPLOYER INFORMATION

The Carle Foundation
611 West Park Street
Urbana, IL 61801
(217) 902-5310

The Carle Foundation Hospital
611 West Park Street
Urbana, IL 61801
(217) 902-5310

Carle Holding Company, Inc.
611 West Park Street
Urbana, IL 61801
(217) 902-5310

Carle Health Care Incorporated
d/b/a/ Carle Physician Group
611 West Park Street
Urbana, IL 61801
(217) 902-5310

Carle West Physician Group, Inc.
611 West Park Street
Urbana, IL 61801
(217) 902-5310

Hoopeston Community Memorial Hospital
d/b/a Carle Hoopeston Regional Health Center
701 E. Orange Street
Hoopeston, IL 60942
(217) 902-5310

Carle BroMenn Medical Center
1304 Franklin Ave.
Normal, IL 61761
(217) 902-5310

Carle Eureka Hospital
101 S. Major St.
Eureka, IL 61530
(217) 902-5310

Richland Memorial Hospital, Inc.
d/b/a Carle Richland Memorial Hospital
800 E. Locust St.
Olney, IL 62450
(217) 902-5310

**PLAN ADMINISTRATOR**

The Carle Foundation
611 West Park Street
Urbana, IL 61801
(217) 902-5310

**PLAN SPONSOR**

The Carle Foundation
611 West Park Street
Urbana, IL 61801
(217) 902-5310

**NAMED FIDUCIARY**

The Carle Foundation
611 West Park Street
Urbana, IL 61801

## GENERAL PLAN INFORMATION

### AGENT FOR SERVICE OF LEGAL PROCESS

The Carle Foundation
611 West Park Street
Urbana, IL 61801
(217) 902-5310

### CARLE FOUNDATION BENEFITS DEPARTMENT

The Carle Foundation Benefits Department
(217) 902-5310
Fax: (217) 902-7802
Benefits@Carle.com

### CARLE FOUNDATION HUMAN RESOURCES DEPARTMENT

The Carle Foundation Human Resources Department
(217) 902-5300
Human.Resources@Carle.com

### THIRD PARTY ADMINISTRATOR

Health Alliance Medical Plans, Inc.
3310 Fields South Drive
Champaign, IL 61822
(800) 322-7451
HealthAlliance.org (**Note:** Covered Persons must create a login to view the Provider Directory and other Plan-related information.)

### UTILIZATION REVIEW MANAGER

Health Alliance Medical Plans, Inc.
(800) 322-7451

### NURSE CONTACT FOR GENERAL HEALTH INFORMATION

In the case of an emergency, call 911. For non-emergency health questions, Covered Persons may call and speak with a nurse about general health information at (855) 802-4612.

**Please Note:** For information about Plan benefits, call customer service whose phone number can be found on the Plan ID Card.

### PHARMACY BENEFIT MANAGER

Pharmacy benefit manager: OptumRx® (Health Alliance coordinates all inquiries)

Contact:

Health Alliance Pharmacy Department
3310 Fields South Drive
Champaign, IL 61822
(800) 851-3379, option 4
HealthAlliance.org (**Note:** Covered Persons must create a login to view the Prescription Drug Formulary and other Plan-related information.)
OptumRx.com

## GENERAL PLAN INFORMATION

**COBRA ADMINISTRATOR**

Benefit Planning Consultants (BPC)
2110 Clearlake Blvd., Ste. 200
P.O. Box 7500
Champaign, IL 61826-7500
(217) 355-2300
Fax: (217) 902-9708

**HEALTH SAVINGS ACCOUNT (HSA) CUSTODIAN** (applies to Employees enrolled in the qualified High Deductible Health Plan)

Avidia Bank
(855) 472-9399

**ADVERSE BENEFIT DETERMINATION FACILITATOR**

Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.
3310 Fields South Drive
Champaign, IL 61822
(800) 500-3373
Fax: (217) 902-9708

**EXTERNAL REVIEW FACILITATOR**

Member Relations Department—Appeals
Health Alliance Medical Plans, Inc.
3310 Fields South Drive
Champaign, IL 61822
(800) 500-3373
Fax: (217) 902-9708

**PROVIDER NETWORK AND CLAIM SUBMISSION DETAILS (Also refer to the Plan ID Card)**

| | |
|---|---|
| **Preferred Provider network(s):** | Carle Health & Affiliated Providers Network |
| **Contact information:** | Health Alliance Medical Plans, Inc.<br>3310 Fields South Drive, Champaign, IL 61822<br>(800) 322-7451 \| HealthAlliance.org |
| **Submit MEDICAL claims to:** | Health Alliance Medical Plans, Inc.<br>P.O. Box 6003, Urbana, IL 61803-6003<br>EDI Vendor #77950 |

| | |
|---|---|
| **Extended Network Preferred Provider network(s):** | See the "DEFINED TERMS" section for the definition of "Extended Network Provider". |
| **Contact information:** | Health Alliance Medical Plans, Inc.<br>3310 Fields South Drive, Champaign, IL 61822<br>(800) 322-7451 \| HealthAlliance.org |
| **Submit MEDICAL claims to:** | Health Alliance Medical Plans, Inc.<br>P.O. Box 6003, Urbana, IL 61803-6003<br>EDI Vendor #77950 |

| | |
|---|---|
| **Provider network(s):** | First Health® Complementary Network |
| **Applicability:** | All Covered Persons for health care situations that require immediate care when such care cannot be arranged at a Preferred Provider.<br>Accessing this network may reduce the cost a Covered Person pays to a Non-Preferred Provider when that Provider is part of the First Health Network. |
| **Contact information:** | Health Alliance Medical Plans, Inc.<br>3310 Fields South Drive, Champaign, IL 61822<br>(800) 322-7451 **|** HealthAlliance.org **or** FirstHealthComplementary.com |

**NON-PREFERRED PROVIDER CLAIM SUBMISSION DETAILS**

**Send Non-Preferred Provider claims to:**

Health Alliance Medical Plans, Inc.
P.O. Box 6003
Urbana, IL 61803-6003
EDI Vendor #77950

**DENTAL CLAIM SUBMISSION DETAILS (Also refer to the Plan ID Card)**

**Send dental claims to:**

Health Alliance Medical Plans, Inc.
P.O. Box 6003
Urbana, IL 61803-6003
EDI Vendor #77950

**PERSONS AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION (PHI) UNDER THE PLAN**

The following designees of the Employer are authorized to receive PHI from the Plan in order to perform their duties with respect to the Plan:

- Plan Administrator;
- Executive Vice President of Human Resources;
- Human Resources Director;
- Human Resources Manager;
- Human Resources Specialist;
- Human Resources personnel;
- Benefits Manager;
- Benefits Assistant;
- Benefits Specialists;
- Payroll personnel;
- Total Rewards Manager;
- ERISA Appeals Committee members; and
- Information Technology staff.

## PREAUTHORIZATION

The Listed Services specified in the subsection "SERVICES REQUIRING PREAUTHORIZATION" must be Preauthorized to verify the services, supplies and treatment are Medically Necessary and to determine if they may be considered as Eligible Expenses under the Plan. Preauthorization must be initiated by calling (1) the phone number listed on the Plan ID Card, or (2) the Utilization Review Manager whose phone number can be found in the "GENERAL PLAN INFORMATION" section.

**IMPORTANT! Benefits under the Plan will not be provided for health care services, supplies and treatment that are not Medically Necessary or if the service, supply and treatment being reviewed pursuant to the Preauthorization request is determined not to be an Eligible Expense under the Plan.**

Preauthorization requirements and responsibilities are specified in 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" below.

If the Preauthorization request is approved, both the Covered Person and the Provider who requested the Preauthorization will be notified of the effective dates and the services, supplies and treatment for which benefits are authorized.

If the Preauthorization request is denied, both the Covered Person and the Provider will be notified in writing, and the Plan will not provide benefits for the requested services, supplies and treatment.

Continuing care beyond the expiration date or number of approved visits in the initial Preauthorization request must be Preauthorized by the Utilization Review Manager. If the Covered Person is using an Extended Network Provider or a Non-Preferred Provider and the Preauthorization approval expires, it is the Covered Person's responsibility to notify their Provider so the Provider can determine if further services, supplies and treatment are necessary, and if so, submit another Preauthorization request to the Utilization Review Manager.

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

**PREAUTHORIZATION FOR COVERED PERSONS RESIDING WITHIN 35 MILES OF THE FOLLOWING ZIP CODES: 61801, 61761, 61530, 62450, 60942, OR 28374**

| Type of Provider used: | Preferred Provider (Carle Health & Affiliated Providers Network) | Extended Network Provider (Health Alliance Network) | Non-Preferred Provider |
|---|---|---|---|
| **Plan benefit level** | In-Network/Preferred Provider | • Out-of-Network/Non-Preferred Provider, if the Covered Person fails to obtain Preauthorization as specified in this column of the table.<br>• In-Network/Preferred Provider, if the Covered Person obtains Preauthorization as specified in this column of the table. | Out-of-Network/Non-Preferred Provider |
| **Which plan Network applies?** | Carle Health & Affiliated Providers Network (see "Network" in the "DEFINED TERMS" section for the definition of "Carle Health & Affiliated Providers Network") | Health Alliance Network (see "Network" in the "DEFINED TERMS" section for the definition of "Health Alliance Network") | Non-Preferred Provider, by definition, does not include a plan Network (see the "DEFINED TERMS" section for the definition of "Non-Preferred Provider"). |

## PREAUTHORIZATION

| Type of Provider used: | Preferred Provider (Carle Health & Affiliated Providers Network) | Extended Network Provider (Health Alliance Network) | Non-Preferred Provider |
|---|---|---|---|
| **Is Preauthorization required for the use of the Provider?** | No. Preauthorization for the use of the Preferred Provider is not required. | Yes. Preauthorization for the use of the Extended Network Provider is required, **except** in the case of a Provider accessed for services and treatment for Mental Health Disorders/Substance Use Disorders. | No. Preauthorization for the use of the Non-Preferred Provider is not required. |
| **Who is responsible for Preauthorization of the use of the Provider?** | Not applicable. | The Covered Person is responsible for obtaining Preauthorization of the use of the Extended Network Provider **in advance** of using the Extended Network Provider. | Not applicable. |
| **Is Preauthorization required for any services?** | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. |
| **Who is responsible for obtaining Preauthorization of the Listed Services?** | The Carle Health & Affiliated Providers Network Provider, when providing a Listed Service, is responsible for obtaining Preauthorization of the Listed Services **in advance** of providing the services. | The Covered Person is responsible for obtaining Preauthorization of the Listed Services **in advance** of receiving the services. | The Covered Person is responsible for obtaining Preauthorization of the Listed Services **in advance** of receiving the services. |
| **Are there consequences for failure to obtain Preauthorization of the Listed Services?** | • Carle Health & Affiliated Providers Network Provider, yes. The Carle Health & Affiliated Providers Network Provider's failure to Preauthorize a Listed Service **in advance** of providing it to the Covered Person will result in application of the terms of the Provider Network contract to which the Provider is subject, including but not limited to, appeal rights.<br>• For the Covered Person, no. There is no impact to the Covered Person's benefits for failure to obtain Preauthorization of a Listed Service in advance of receiving it. | Yes, as follows:<br>• If the use of the Extended Network Provider was not Preauthorized **and** the Listed Services were not Preauthorized,<br>**or**<br>• If the use of the Extended Network Provider was not Preauthorized **and** the Listed Services were Preauthorized,<br>then the Covered Person's benefits are subject to the Non-Preferred Provider benefit level. The Preauthorization penalty will apply and will be assessed by reducing the benefit otherwise available by 50% following adjudication of the claim, subject to all Plan provisions and limitations. | Yes. The Covered Person's failure to obtain Preauthorization of the Listed Services will result in a Preauthorization penalty being assessed by reducing the benefit otherwise available by 50% following adjudication of the claim, subject to all Plan provisions and limitations. |

## PREAUTHORIZATION

**PREAUTHORIZATION FOR COVERED PERSONS RESIDING OUTSIDE 35 MILES OF THE FOLLOWING ZIP CODES: 61801, 61761, 61530, 62450, 60942, OR 28374**

| Type of Provider used: | Preferred Provider (Carle Health & Affiliated Providers Network) | Extended Network Provider (Health Alliance Network) | Non-Preferred Provider |
|---|---|---|---|
| **Plan benefit level** | In-Network/Preferred Provider | In-Network/Preferred Provider | Out-of-Network/Non-Preferred Provider |
| **Which plan Network applies?** | Carle Health & Affiliated Providers Network (see "Network" in the "DEFINED TERMS" section for the definition of "Carle Health & Affiliated Providers Network") | Health Alliance Network (see "Network" in the "DEFINED TERMS" section for the definition of "Health Alliance Network") | Non-Preferred Provider, by definition, does not include a plan Network (see the "DEFINED TERMS" section for the definition of "Non-Preferred Provider"). |
| **Is Preauthorization required for the use of the Provider?** | No. Preauthorization for the use of the Preferred Provider is not required. | No. Preauthorization for the use of the Extended Network Provider is not required. | No. Preauthorization for the use of the Non-Preferred Provider is not required. |
| **Who is responsible for Preauthorization of the use of the Provider?** | Not applicable. | Not applicable. | Not applicable. |
| **Is Preauthorization required for any services?** | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. | Yes. Preauthorization is **always** required for the Listed Services specified in the "SERVICES REQUIRING PREAUTHORIZATION" section. |
| **Who is responsible for obtaining Preauthorization of the Listed Services?** | The Carle Health & Affiliated Providers Network Provider is responsible for obtaining Preauthorization of the Listed Services **in advance** of providing the services. | The Covered Person is responsible for obtaining Preauthorization of the Listed Services **in advance** of receiving the services. | The Covered Person is responsible for obtaining Preauthorization of the Listed Services **in advance** of receiving the services. |
| **Are there consequences for failure to obtain Preauthorization of the Listed Services?** | • For the Carle Health & Affiliated Providers Network Provider, yes. The Network Provider's failure to Preauthorize a Listed Service **in advance** of providing it to the Covered Person will result in application of the terms of the Provider network contract to which the Provider is subject, including but not limited to, appeal rights.<br>• For the Covered Person, no. There is no impact to the Covered Person's benefits for failure to obtain Preauthorization of a Listed Service in advance of receiving it. | The Covered Person's failure to Preauthorize a Listed Service **in advance** of receiving it will result in the Plan's Preauthorization penalty being assessed by reducing the benefit otherwise available by 50% following adjudication of the claim, subject to all Plan provisions and limitations. | Yes. The Covered Person's failure to obtain Preauthorization of the Listed Services will result in a Preauthorization penalty being assessed by reducing the benefit otherwise available by 50% following adjudication of the claim, subject to all Plan provisions and limitations. |

## PREAUTHORIZATION

### 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 and non-urgent ground)
- Bariatric surgery
- Blepharoplasty and eye brow lift/brow ptotis
- 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 services
- Genetic testing (including molecular diagnostics)—select (Providers may visit HealthAlliance.org for specific CPT/HCPCS codes) — NOTE: Effective July 1, 2022, the following prenatal genetic testing CPT codes do not require Preauthorization: 81420 and 81507.
- Hyperbaric oxygen therapy
- Imaging:
  - CT
  - CTA
  - MRI
  - MRA
  - PET
  - 3D (3D mammography does not require Preauthorization)
  - Through July 31, 2022: Obstetrical and diagnostic ultrasound (NOTE: Breast ultrasounds and venous duplex (Doppler) scans do not require Preauthorization.)
    Effective August 1, 2022: Obstetric and diagnostic ultrasounds do not require Preauthorization.
- Infertility services (all diagnostic tests, medications, treatments, etc.)
- Inpatient rehabilitation services

- Interstim: implantable sacral nerve stimulation for urinary dysfunction
- Interventional pain management
- Joint surgery (select) (Providers may visit HealthAlliance.org for specific CPT/HCPCS codes)
- Laser treatment of psoriasis
- Oncology Pathways (inpatient chemotherapy does not require Preauthorization)
- Out-of-network referral for HMO
- Port wine stain removal
- 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 (Providers may visit HealthAlliance.org for specific CPT/HCPCS codes)
- Skilled Nursing Facility
- Sleep diagnostics, evaluations and supplies
- Specialty Pharmacy (including home infusion drugs)—select (Providers may visit HealthAlliance.org for specific CPT/HCPCS codes)
- Spine surgery (select) (Providers may visit HealthAlliance.org for specific CPT/HCPCS codes)
- Transcranial magnetic stimulation (TMS) treatment
- Transplant services
- Urgent inpatient stays (medical/surgical, Substance Use Disorder) (notification required; no review)
- 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.

## CASE MANAGEMENT SERVICES

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

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

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

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

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

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

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

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

For more information, contact the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.

## PREFERRED PROVIDER OPTION (PPO) PLAN

**IMPORTANT! PLEASE NOTE:**

- If the Employer offers multiple Plan options (e.g., PPO Plan; PPO HDHP), the Covered Person must understand what Plan option he or she they selected to know which Plan option section and "SCHEDULE OF BENEFITS" subsection applies.

The PPO Plan allows Covered Persons to choose their health care services Providers. The Plan benefit level is determined by the type of Provider used and the terms of the Plan. There are three types of Providers, and the benefit level may be impacted based on which is used. The three types of Providers are: Preferred Providers, Extended Network Providers and Non-Preferred Providers.

The Plan has made arrangements to obtain access to certain Hospitals, Physicians and other health care Providers that comprise the Carle Health & Affiliated Providers Network (which are referred to as Preferred Providers) and the Health Alliance Network (which are referred to as Extended Network Providers). Because these Preferred Providers and Extended Network Providers have agreed to charge reduced fees to Covered Persons participating in the Plan, the Plan may reimburse a higher percentage of the Preferred Provider and Extended Network Provider fees.

**Services Received from Preferred Providers and Extended Network Providers.**

- Covered Persons who receive services from a Preferred Provider will generally receive the highest (or the best) level of Plan benefits.
- The benefit level for using an Extended Network Provider is dependent upon where the Employee or Retired Employee resides and whether or not Preauthorization requirements are followed by the Covered Person, unless specifically indicated herein to the contrary.
- Benefits received for health care services provided by Preferred Providers and Extended Network Providers are payable by the Plan as specified in the "SCHEDULE OF BENEFITS" section after any applicable individual or family Deductible has been met.
- Benefits for expenses incurred for services provided by Preferred Providers or Extended Network Providers are not subject to the Maximum Allowable Charge limitations, unless the contract includes such limitations.
- After Covered Persons provide the necessary information, Preferred Providers and Extended Network Providers will submit claims to the Third Party Administrator on their behalf.

**Services Received from Non-Preferred Providers.**

- Covered Persons who receive services, other than Emergency Services, from a Non-Preferred Provider will generally receive a lower level of Plan benefits and have more out-of-pocket expenses, and possibly no benefits under the Plan, unless otherwise specifically provided herein.
- Benefits received for health care services provided by Non-Preferred Providers are payable by the Plan as specified in the "SCHEDULE OF BENEFITS" section, up to the Maximum Allowable Charges, after any applicable individual or family Deductible has been met.
    - Be aware that when the services of a Non-Preferred Provider are used in nonemergency situations, benefit payments to such Non-Preferred Provider are not based upon the amount billed. The basis of the benefit payment is determined according to the Maximum Allowable Charge. Covered Persons can expect to pay more than the Coinsurance amount after the Plan has paid its portion. Non-Preferred Providers may bill a Covered Person for any amount up to the billed amount after the Plan has paid its portion of the bill.
- Covered Persons are responsible for submitting claims or bills to the Third Party Administrator if the Provider does not agree to send a claim on their behalf. Providers will bill the portion Covered Persons are responsible for directly to them after the Plan has determined its payment.
- <u>The following applies for Plan Years beginning on or after January 1, 2022</u>: See also "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES" at the end of the "MEDICAL BENEFITS" section.

## PREFERRED PROVIDER OPTION (PPO) PLAN

**IMPORTANT! PLEASE NOTE:**

- If the Employer offers multiple Plan options (e.g., PPO Plan; PPO HDHP), the Covered Person must understand what Plan option they selected to know which Plan option section and "SCHEDULE OF BENEFITS" subsection applies.

**Network Information.** See "PROVIDER NETWORK AND CLAIM SUBMISSION DETAILS" in the "GENERAL PLAN INFORMATION" section for details. The network information can also be found on the Plan ID Card.

**PLEASE NOTE: The Network applicability and benefit levels described herein apply to Employees, Retired Employees and Dependents based on the Employee's or Retired Employee's address, regardless of where the Dependent resides (except for a Dependent child who is approved to participate in the Student Extended Network Program. See also the "STUDENT EXTENDED NETWORK PROGRAM" section).**

**Provider Directory.** A Provider Directory of Preferred Providers and Extended Network Providers for the Plan is available on the Third Party Administrator's website whose site address can be found in the "GENERAL PLAN INFORMATION" section. When accessing the website, the Covered Person must create and use a login to view the Plan's Provider Directory. In the site, click on "Menu", "Plan & Benefits", Find Care" and "Find Doctors or Facilities". The Provider Directory lists the Providers by specialty. Covered Persons who do not have access to the Internet or prefer to receive a printed copy of the Provider Directory may 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.

## 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]; 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.

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

| 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 |

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

| TYPE OF MEDICAL EXPENSE | You Pay<br>Preferred Providers | You Pay<br>Non-Preferred Providers |
|---|---|---|
| Human organ transplant services<br>(**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<br>Deductible waived | 50% Coinsurance, after Deductible |
| Office visit—specialty care | $40 Copayment per visit<br>Deductible waived | 50% Coinsurance, after Deductible |
| Office visit—Mental Health Disorder/Substance Use Disorder services and treatment [6] | $20 Copayment per visit<br>Deductible waived | 50% Coinsurance, after Deductible |
| Routine eye exams | $40 Copayment per exam<br>Deductible waived | 50% Coinsurance, after Deductible |
| Telehealth services<br>**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:<br>$0 Copayment per visit,<br>Deductible waived<br>Visits 4 and over:<br>$20 Copayment per visit,<br>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<br>(Preferred Provider benefit level applies) |
| Emergency Services [3] | Visits 1–2:<br>$200 Copayment,<br>Deductible, then 20% Coinsurance,<br>per Covered Person per visit<br>Visits 3 and over:<br>$500 Copayment,<br>Deductible, then 20% Coinsurance<br>per Covered Person per visit | Visits 1–2:<br>$200 Copayment,<br>Deductible, then 20% Coinsurance,<br>per Covered Person per visit<br>Visits 3 and over:<br>$500 Copayment,<br>Deductible, then 20% Coinsurance<br>per Covered Person per visit<br>(Preferred Provider benefit level applies for all visits) |

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

| TYPE OF MEDICAL EXPENSE | You Pay<br>Preferred Providers | You Pay<br>Non-Preferred Providers |
|---|---|---|
| Urgent Care facility | 20% Coinsurance, after Deductible | 20% Coinsurance, after Deductible<br>(Preferred Provider benefit level applies) |
| Preventive care services [4] | 0% Coinsurance<br>Deductible waived | 50% Coinsurance, after Deductible |
| Additional surgical opinion | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Diagnostic testing (X-rays, medical imaging, laboratory services)<br>**Note:** For benefit details relating to COVID-19, see the "ADDENDUM: COVID-19" section. | 20% Coinsurance, after Deductible | 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<br>(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 |

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

| TYPE OF MEDICAL EXPENSE | You Pay Preferred Providers | You Pay Non-Preferred Providers |
|---|---|---|
| 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*.

## SCHEDULE OF BENEFITS

## MEDICAL AND PRESCRIPTION DRUG BENEFITS

## PLAN: PPO PLAN OPTION

| TYPE OF PRESCRIPTION DRUG EXPENSE | You Pay* Preferred Pharmacy | You Pay* Non-Preferred Pharmacy |
|---|---|---|
| Retail and Specialty Prescription Drugs [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 30-day supply<br>• includes retail and Specialty Infertility prescriptions<br>• Deductible is waived on each tier level<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script<br>**Tier 2 (Non-Preferred generic):** $10 Copayment per script<br>**Tier 3 (Preferred brand):** $40 Copayment per script<br>**Tier 4 (Non-Preferred brand):** $60 Copayment per script<br>**Tier 5 (Preferred Specialty):** 30% Coinsurance per script<br>**Tier 6 (Non-Preferred Specialty):** 30% Coinsurance per script | *Not considered an Eligible Expense* |
| Retail 90 program at retail Pharmacies [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 90-day supply<br>• includes Specialty Infertility prescriptions<br>• Deductible is waived on each tier level<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script<br>**Tier 2 (Non-Preferred generic):** $27.50 Copayment per script<br>**Tier 3 (Preferred brand):** $110 Copayment per script<br>**Tier 4 (Non-Preferred brand):** $165 Copayment per script | *Not considered an Eligible Expense* |
| Mail-order Prescription Drugs [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 90-day supply<br>• includes Specialty Infertility prescriptions<br>• Deductible is waived on each tier level<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script<br>**Tier 2 (Non-Preferred generic):** $27.50 Copayment per script<br>**Tier 3 (Preferred brand):** $110 Copayment per script<br>**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<br>(Deductible waived) | *Not considered an Eligible Expense* |

## SCHEDULE OF BENEFITS

## MEDICAL AND PRESCRIPTION DRUG BENEFITS

## PLAN: PPO PLAN OPTION

| TYPE OF PRESCRIPTION DRUG EXPENSE | You Pay* Preferred Pharmacy | You Pay* Non-Preferred Pharmacy |
|---|---|---|
| Prescription Pharmacy Contraceptives [1, 4] (e.g., oral Contraceptives, patches, ring)<br>• limited to one Contraceptive product per month<br>• Deductible is waived on each tier level | **Tier 1 (Preferred generic):** $0 Copayment per product<br>**Tier 2 (Non-Preferred generic):** $10 Copayment per product<br>**Tier 3 (Preferred brand):** $40 Copayment per product<br>**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<br>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.

## SCHEDULE OF BENEFITS

## MEDICAL AND PRESCRIPTION DRUG BENEFITS

## PLAN: PPO PLAN OPTION

**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.

# SCHEDULE OF BENEFITS
# MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) 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 | $2,000 | $4,000 |
| Family Unit coverage | $4,000 | $8,000 |

Deductibles apply to all services/benefits, if determined to be Eligible Expenses, except the following when provided by a Preferred Provider:

- preventive care services [4].

For Family Unit coverage: If two or more family members are enrolled in the Plan, the Family Unit Deductible can be satisfied by one family member or a combination of family members. One family member could reach the full Family Unit Deductible for the entire family.

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

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

| 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 | $5,500 | $25,000 |
| Family Unit coverage | $11,000 | $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: Any combination of family members may satisfy the Family Unit Out-of-Pocket Maximums.

| 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 |

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

| TYPE OF MEDICAL EXPENSE | You Pay<br>Preferred Providers | You Pay<br>Non-Preferred Providers |
|---|---|---|
| Human organ transplant services<br>(**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% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Office visit—specialty care | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Office visit—Mental Health Disorder/Substance Use Disorder services and treatment [6] | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Routine eye exams | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Telehealth services<br>**Note:** For benefit details relating to COVID-19, see the "ADDENDUM: COVID-19" section. | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Virtual visits | 20% Coinsurance, after Deductible | *Not considered an Eligible Expense* |
| Routine prenatal care visit [5] | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |
| Ambulance services [3] | 20% Coinsurance, after Deductible | 20% Coinsurance, after Deductible<br>(Preferred Provider benefit level applies) |
| Emergency Services [3] | Visits 1–2:<br>20% Coinsurance, after Deductible, per Covered Person per visit<br>Visits 3+:<br>30% Coinsurance, after Deductible, per Covered Person per visit | Visits 1–2:<br>20% Coinsurance, after Deductible, per Covered Person per visit<br>Visits 3+:<br>30% Coinsurance, after Deductible, per Covered Person per visit<br>(Preferred Provider benefit level applies for all visits) |
| Urgent care facility | 20% Coinsurance, after Deductible | 20% Coinsurance, after Deductible<br>(Preferred Provider benefit level applies) |
| Preventive care services [4] | 0% Coinsurance<br>Deductible waived | 50% Coinsurance, after Deductible |
| Additional surgical opinion | 20% Coinsurance, after Deductible | 50% Coinsurance, after Deductible |

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

| TYPE OF MEDICAL EXPENSE | You Pay<br>Preferred Providers | You Pay<br>Non-Preferred Providers |
|---|---|---|
| Diagnostic testing (X-rays, medical imaging, laboratory services)<br>**Note:** For benefit details relating to COVID-19, see the "ADDENDUM: COVID-19" section. | 20% Coinsurance, after Deductible | 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<br>(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 |

# SCHEDULE OF BENEFITS
# MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

**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.*

## SCHEDULE OF BENEFITS

## MEDICAL AND PRESCRIPTION DRUG BENEFITS

## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

| TYPE OF PRESCRIPTION DRUG EXPENSE | You Pay* Preferred Pharmacy | You Pay* Non-Preferred Pharmacy |
|---|---|---|
| Retail and Specialty Prescription Drugs [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 30-day supply<br>• includes retail and Specialty Infertility prescriptions<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script, after Deductible<br>**Tier 2 (Non-Preferred generic):** $10 Copayment per script, after Deductible<br>**Tier 3 (Preferred brand):** $40 Copayment per script, after Deductible<br>**Tier 4 (Non-Preferred brand):** $80 Copayment per script, after Deductible<br>**Tier 5 (Preferred Specialty):** 20% Coinsurance per script, after Deductible<br>**Tier 6 (Non-Preferred Specialty):** 50% Coinsurance per script, after Deductible | *Not considered an Eligible Expense* |
| Retail 90 program at retail Pharmacies [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 90-day supply<br>• includes Specialty Infertility prescriptions<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script, after Deductible<br>**Tier 2 (Non-Preferred generic):** $27.50 Copayment per script, after Deductible<br>**Tier 3 (Preferred brand):** $110 Copayment per script, after Deductible<br>**Tier 4 (Non-Preferred brand):** $220 Copayment per script, after Deductible | *Not considered an Eligible Expense* |
| Mail-order Prescription Drugs [1, 2]<br>• mandatory generic substitution<br>• limited to a maximum 90-day supply<br>• includes Specialty Infertility prescriptions<br>• Preauthorization is required for Specialty Prescription Drugs | **Tier 1 (Preferred generic):** $0 Copayment per script, after Deductible<br>**Tier 2 (Non-Preferred generic):** $27.50 Copayment per script, after Deductible<br>**Tier 3 (Preferred brand):** $110 Copayment per script, after Deductible<br>**Tier 4 (Non-Preferred brand):** $220 Copayment per script, after Deductible | *Not considered an Eligible Expense* |

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

| TYPE OF PRESCRIPTION DRUG EXPENSE | You Pay* Preferred Pharmacy | You Pay* Non-Preferred Pharmacy |
|---|---|---|
| Retail tobacco cessation drugs (when enrolled in the Quit for Life® program) [1, 3] | $15 Copayment per script, after Deductible | *Not considered an Eligible Expense* |
| Prescription Pharmacy Contraceptives [1, 4] (e.g., oral Contraceptives, patches, ring)<br>• limited to one Contraceptive product per month | **Tier 1 (Preferred generic):** $0 Copayment per product, Deductible waived<br>**Tier 2 (Non-Preferred generic):** $10 Copayment per product, after Deductible<br>**Tier 3 (Preferred brand):** $40 Copayment per product, after Deductible<br>**Tier 4 (Non-Preferred brand):** $80 Copayment per product, after Deductible | *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.

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

**PLEASE NOTE:**

- The following applies to Covered Persons enrolled in a qualified high deductible health Plan (HDHP): A qualified HDHP satisfies certain regulatory/statutory requirements issued by the U.S. Department of the Treasury with respect to minimum deductibles and maximum out-of-pocket expenses for both single and family coverage. A HDHP that is paired with a health savings account (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 services.

  Under a qualified HDHP (a plan which is paired with a HSA), 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 the U.S. Department of the Treasury guidance: HDHPs are not permitted to apply the following toward satisfaction of required Deductible(s):
  - Subsidies;
  - Coupons;
  - Rebates;
  - Post-purchase reimbursements; and
  - Other cost sharing assistance provided to the Covered Person by third party entities, including but not limited to the manufacturer.

  The above list represents examples and is not exhaustive.

- 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.

## SCHEDULE OF BENEFITS
## MEDICAL AND PRESCRIPTION DRUG BENEFITS
## PLAN: PPO HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

**HEALTH SAVINGS ACCOUNT (this requires enrollment in the HDHP Option)**

The Health Savings Account (HSA) is not an Employer-sponsored employee benefit plan—it is a custodial account that the Employee (also referred to as "you" or "your" in this subsection) opens with the HSA Custodian designated by the Employer as specified in the "GENERAL PLAN INFORMATION" section. The HSA is to be used primarily for reimbursement of eligible medical expenses. An Employee must establish their HSA with the HSA Custodian (not the Employer). The Employer's role is allowing Employees to contribute to an HSA on a pre-tax salary reduction basis, and making discretionary employer contributions to the HSA.

**Eligibility.** If you are a benefits-eligible Employee and an "HSA-Eligible Individual," you are eligible to participate in the HSA. You are an "HSA-Eligible Individual" if you have elected to participate in the Employer's qualifying high deductible health plan (HDHP) (i.e., the HDHP with Health Savings Account option) and have not elected any disqualifying non-high deductible health plan coverage. You become eligible to enroll in the HSA described in this section at the time you enroll in the HDHP with Health Savings Account option.

Specifically, you are eligible to contribute to an HSA if you meet the following criteria:

- You are enrolled in the HDHP with Health Savings Account option;
- You are not enrolled in Medicare or Medicaid (including Medicare Part A);
- You are not enrolled in Tricare military coverage;
- You have not received any Veterans Administration (VA) health benefits in the last three months (this rule does not apply to any hospital care or medical services received from the VA by a veteran who has a disability rating from the VA);
- You are not claimed as a dependent on someone else's tax return; and
- You are not covered by another health plan that is not a high deductible health plan and that provides benefits already covered under the Employer's HDHP option. This includes coverage received through your spouse's medical plan, or participation in a general purpose healthcare flexible spending account (FSA) (including if your spouse participates in a general purpose healthcare FSA).

You can, however, still contribute to an HSA if you have additional health plan coverage that provides benefits only for the following items: liabilities incurred under workers' compensation laws, tort liabilities or liabilities related to ownership or use of property; a specific disease or illness; or a fixed amount per day (or other period) of hospitalization.

You can also contribute to an HSA even though you have other health plan coverage for accidents, disability, dental care, vision care, or long-term care.

Please note that if you are enrolled in the HDHP with Health Savings Account option, you are not eligible to also participate in the healthcare FSA but may participate in the limited-use health care FSA, under which you may only pay for eligible dental and vision expenses.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

**Enrollment.** In order to elect HSA benefits under the HSA plan, you must elect an HSA through the benefits enrollment platform and then establish and maintain an HSA with the HSA Custodian. You must provide sufficient identifying information about your HSA to facilitate the set-up of your account and allow forwarding of your pre-tax salary reductions through the Employer's payroll system to the HSA Custodian. ***Important! Enrollment in an HSA is not automatic; it is optional.***

Your participation will take effect as of the Effective Date of your enrollment in the HDHP – if you provide appropriate documentation to open the account with the HSA Custodian. You must re-elect the HSA each Benefit Period you wish to have pre-tax deductions forwarded to the account with the HSA Custodian.

Please note you may increase, decrease, or revoke your HSA contribution election at any time for any reason by submitting an election change request to the Carle Benefits Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section. Your election change will be prospectively effective as of the next pay period following the date you submit your election change.

**Reimbursement.** You can use your HSA to reimburse the cost of qualifying medical expenses (other than most types of health plan coverage premiums/contributions, with certain exceptions) incurred by you or your "qualifying dependents" under IRC Section 223 on a tax-free basis. Examples of qualifying medical expenses include deductibles, copayments, coinsurance amounts, COBRA premiums, eyeglasses, contact lenses, and prescription drugs; provided that amounts paid for over-the-counter medicines are not eligible medical expenses (unless such medicine is insulin or is prescribed by an appropriately licensed health care professional).

Qualifying medical expenses must be incurred after your HSA is established in order to be reimbursable on a tax-free basis.

The maximum amount you can contribute to the HSA depends on the level of coverage you elect and is defined by the Internal Revenue Service each year.

In addition, your maximum allowable contribution will be reduced by any Employer contribution made on your behalf and will be prorated for months in which you are an "HSA-Eligible Individual." The Employer will contribute a predetermined amount each Benefit Period for enrolled participants. The Employer reserves the right to change its HSA contribution amount in its sole discretion and will communicate changes to participants. Benefit Period predetermined contribution amounts will be communicated by the Employer. If you enroll in the HSA mid-Benefit Period, the Employer will prorate the contribution you receive.

Note that if you are an "HSA-Eligible Individual" for only part of the Benefit Period but you meet all of the requirements under IRC Section 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the HSA plan for HSA benefits, but not in excess of the applicable full statutory maximum amount, must be made outside the HSA plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of IRC Section 223 during the following Benefit Period, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a financial penalty as determined by the Internal Revenue Service (IRS) and may change from time to time (exceptions apply in the event of death or disability). For the most current information, visit the IRS website at IRS.gov.

Your "qualifying dependents" for purposes of HSA benefits include your spouse, your qualifying child and your qualifying relative, defined as follows:

- "Qualifying child" means your relative (generally your child or grandchild, brother, sister, stepbrother, or stepsister or a descendant of any such relative) who meets the following additional conditions:
  - Is under age 19, or under age 24 and a full-time student (or any age if totally and permanently disabled); and
  - Lives with you for more than 50% of the Benefit Period. (Temporary absences due to special circumstances, such as illness, education, business, vacation or military service are not treated as absences); and
  - Does not provide more than 50% of their own annual financial support.

- "Qualifying relative" means your domestic partner, a child of your domestic partner, child for whom you are legal guardian, or other individual who:
  - Is either your relative (including your child or grandchild, sibling or step-sibling, parent or ancestor of your parent, step-parent, niece or nephew, aunt or uncle, son-in-law, daughter-in-law, parent-in-law, or sibling-in-law), or is another individual who lives with you and is a member of your household;
  - Receives more than 50% of their annual financial support from you; and
  - Is not a qualifying child of you or any other taxpayer during the Benefit Period.

*Special Rule for Child of Parents Who Are Divorced or Separated*—A special exception applies in the case of a child of parents who are divorced or legally separated, or who live apart at all times during the last six months of the Benefit Period. Such a child may be your "qualifying dependent" for HSA purposes, even if the child is not your qualifying child or qualifying relative, if the child:

- receives over 50% of their support during the Benefit Period from their parents,
- is in the custody of one or both parents for more than 50% of the Benefit Period, and
- qualifies as a tax dependent of one of their parents under IRC Section 152I or 152(d).

**When HSA Enrollment Ends.** Your contributions to your HSA automatically will end on:

- the last day of the month on which you terminate employment;
- the last day of the period for which the last required contribution was made if you fail to make a required contribution when due;
- the last day of the calendar month on which you transfer to a job position in which you are not eligible to participate in the HDHP option;
- the last day of the calendar month on which you cease to be actively at work unless your enrollment can be continued under the Employer's leave of absence policy;
- the date of your death;
- the effective date of a Plan amendment that discontinues your eligibility for an HSA; or
- the date the Plan, or the HSA under the Plan, is terminated.

Your HSA belongs to you. You maintain it and continue to receive reimbursements for qualifying medical expenses after you terminate employment with the Employer. COBRA continuation coverage does not apply to your HSA, and you will not receive an HSA contribution from the Employer even if you elect COBRA continuation coverage under the HDHP option.

You may also elect to terminate your enrollment in an HSA during Open Enrollment or at any other time during the Benefit Period.

***Example*: Annual Tax Savings.** As noted, when you pay for benefits on a pre-tax basis, the Employer deducts the amount from your base pay before any deductions for federal and state income taxes, Social Security, and Medicare (i.e. FICA) taxes. This example shows how an HSA can save you money. Let's assume:

- You are married;
- Your family income is $30,000 a year; and
- You decide to contribute $750 to an HSA.

| | With an HSA | Without an HSA |
|---|---|---|
| Family income | $30,000 | $30,000 |
| Pre-tax health care HSA contribution | -$750 | -$0 |
| Taxable income | $29,250 | $30,000 |
| Federal, state, and Social Security taxes* | $6,625 | $6,795 |
| Take-home pay | $22,625 | $23,205 |
| After-tax health care expenses | -$0 | -$750 |
| Spendable pay | $22,625 | $22,455 |
| Annual tax savings | $170 | $0 |
| **Note:** This example assumes 15% federal income tax, 6.2% Social Security tax, and 1.45% Medicare hospital insurance tax. This is only an illustration; your savings may vary. | | |

If a distribution is made from your HSA and is not used for your qualified medical expenses or the qualified medical expenses of your qualifying dependents, the distribution is includible in your gross income and generally is subject to an additional tax as determined by the Internal Revenue Service (IRS) and may change from time to time.

Please remember that your HSA is not sponsored by the Employer and is not part of the Plan. The Employer has no authority or control over the funds deposited in your HSA, and your HSA is not subject to ERISA. If you have questions regarding the HSA benefit, you should contact the HSA Custodian as specified in the "GENERAL PLAN INFORMATION" section.

## STUDENT EXTENDED NETWORK PROGRAM

The Student Extended Network Program ("Program") may be a solution for a student who:

- is an eligible Dependent child;
- is enrolled in the Plan;
- attends an academic entity outside the Plan's standard network area;
- will be in attendance for 90-consecutive days or longer; **and**
- does not have access to a Preferred Provider where they reside for the purpose of attending the academic entity.

The Program is not available to eligible Dependent children who have adequate access to a Preferred Provider or to eligible Dependent children who permanently reside outside the Plan's standard network area.

Following is the network information for the Program. The network information can also be found on the Dependent child's Plan ID Card.

| **Preferred Provider network(s):** | **Contact information:** |
|---|---|
| First Health wrap network | Health Alliance Medical Plans, Inc.<br>3310 Fields South Drive, Champaign, IL 61822<br>(800) 322-7451<br>HealthAlliance.org |

For complete information about the Program rules, requirements and benefits, 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. Completion of a student verification form is required at certain intervals.

# ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

Individuals may contact the Plan Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section to obtain additional information about eligibility for Plan coverage. Failure to follow the eligibility and enrollment requirements as described herein may result in a delay of coverage or no coverage at all.

**NOTE:** If a Covered Person is not eligible for Plan coverage and information has been withheld or omitted which would constitute fraud or intentional misrepresentation of information, and Providers have been reimbursed for services and supplies provided to the Covered Person, any such Covered Person (or responsible parent or guardian in the case of a minor) will be required to reimburse the Plan for any and all amounts paid on their behalf for health care services together with any reasonable attorneys' fees and expenses incurred in collection of such amounts.

## EMPLOYEE COVERAGE: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

**Eligible Classes of Employees.** Eligible classes of Employees include:

**(1)** all Active Employees of the Employer; and

**(2)** other persons for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that they:

**(1)** are a permanent, Active Employee of the Employer. An Employee is considered eligible if they normally work at least 20 hours per week as an Employee classified as employment code A1, A2, A3 or A5. Employees classified with employment codes A6 or A7 are not eligible for Plan coverage.

The eligibility date for an Employee who changes employment codes will be the effective date of the employment code change.

An Employee's status as a full-time or part-time Employee will be determined on the basis of the average number of hours scheduled to work. Hours worked will be reviewed by the Employer every six months to ensure Employees are placed in the correct status. The Employer will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation pay, etc.). Plan coverage will continue as long as the Employee remains in an eligible employment code classification.

**(2)** is in a class eligible for coverage.

**Enrollment Requirements for Employee Coverage.** An eligible Employee must enroll for coverage within 31 days of satisfying the requirements specified in the "Eligibility Requirements for Employee Coverage" subsection by completing the online enrollment requirements established by the Employer. If the Employee elects to provide coverage for their eligible Dependents, then the Employee is required to enroll for Dependent coverage also. For more details about the enrollment process, the Employee must contact The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

**Selection of Coverage.** An Employee may elect coverage for medical benefits, medical and dental benefits, or dental benefits only. An Employee must be enrolled in the benefit being elected for their Dependent(s). For example, if an Employee elects medical and dental coverage, the Employee can enroll their Dependent(s) for medical benefits only, dental benefits only, or medical and dental benefits.

**NOTE:** Dental benefits are offered separately from the medical benefits and are required to be elected separately for coverage to be effective. See also the "DENTAL BENEFITS" section.

Any changes in benefits or coverage must be made during the designated Open Enrollment period or within 31 days of a qualifying change-in-status event.

**Effective Date of Employee Coverage.** An Employee will be covered under the Plan as of the first day that they satisfy all of the following:

**(1)** The eligibility requirements of the Plan. (Refer to the "Eligibility Requirements for Employee Coverage" subsection above.)

**(2)** The enrollment requirements of the Plan. (Refer to the "Enrollment Requirements for Employee Coverage" subsection above.)

**Effective Dates for Employees Returning from Terminated Status, Layoff or Leave of Absence.**

| Question: | Answer: |
|---|---|
| For a *terminated Employee who is rehired by the Employer*, when does their Plan coverage become effective? | Unless otherwise specified by the Employer, a terminated Employee who is rehired, including an Employee who is rehired within 30 days of their termination date, will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements of the Plan. If an Employee is terminated and rehired by the Employer within the same Benefit Period, credit will be provided for Deductible and Out-of-Pocket Maximum amounts accumulated prior to the termination date. Deductible and Out-of-Pocket Maximum amounts accumulated during any period for which the person was covered under COBRA will also be credited. |
| For an *Employee who returns to work from a layoff*, when does their Plan coverage become effective? | The Employee is treated as a new hire and required to satisfy the eligibility and enrollment requirements of the Plan. |
| For an *Employee who returns to work from a non-FMLA leave of absence*, when does their Plan coverage become effective? | If the Employee returns to work within 30 days of their non-FMLA leave of absence date, the Employee's coverage will take effect on the date they return to work. Any applicable waiting period is waived. |

## RETIRED EMPLOYEE COVERAGE: ELIGIBILITY AND EFFECTIVE DATES

**Eligible Classes of Employees.** Eligible classes of employees include:

- Qualified Retired Employees of the Employer; and
- other persons for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order.

**Eligibility Requirements for Retired Employee Coverage.** For an Employee to be eligible for Retired Employee coverage, they must meet the definition of "Retired Employee" (see "Retired Employee (Retiree)" in the "DEFINED TERMS" section).

**Retired Employee Coverage Details.** The Retired Employee and their Dependents are eligible for the medical benefits of the Plan only. The Retired Employee and their Dependents are not eligible for the dental benefits of the Plan.

Dependent coverage is limited to those eligible Dependents who were enrolled in the Plan when the Employee retired. If a Retired Employee acquires a new Dependent due to marriage, birth, adoption or placement for adoption, they may enroll the new Dependent in the Plan (see subsection (2) "Acquiring a newly-eligible Dependent may create a Special Enrollment right" in the "SPECIAL ENROLLMENT PERIODS" subsection).

The Retired Employee may terminate Plan coverage for themselves and their Dependents at any time.

Retired Employees and/or their Dependents are not eligible for coverage after becoming Medicare-eligible (age 65).

The Retired Employee is responsible for payment of a premium contribution determined by the Plan Administrator, and the premium contribution may be adjusted from time to time.

The retiree benefits under the Plan may be amended, modified, suspended, withdrawn, discontinued or terminated by the Plan Administrator at any time, for any reason.

**Note:** Upon retirement, an Employee may have the option to choose between COBRA continuation coverage or continuing coverage under the terms of the Plan as a Retired Employee, if the Retired Employee satisfies the criteria above. If the Employee is eligible and chooses to continue coverage under the terms of the Plan as a Retired Employee, they will waive their right to elect COBRA continuation coverage at a later date, unless such date is prior to the expiration of the original COBRA election period. COBRA options may be available to Dependents of Retired Employees due to death or loss of eligibility.

**Effective Date of Retired Employee Coverage.** A Retired Employee will be covered under the Plan as of the first day following the date they satisfy the eligibility requirements of the Plan.

**Effective Date for Employees Returning from Retired Employee Status.** Unless otherwise specified by the Employer, a Retired Employee who is rehired by the Employer will be treated as a new hire. The rehired Employee will be required to satisfy all eligibility and enrollment requirements of the Plan. If an Employee retires and is rehired by the Employer within the same Benefit Period, credit will be provided for Deductible and Out-of-Pocket Maximum amounts accumulated prior to the date they are rehired.

**DEPENDENT COVERAGE: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES**

**Eligible Classes of Employee's Dependents.** A Dependent is considered any one of the following persons:

**(1)** An Employee's Spouse. The Plan Administrator may require documentation proving a legal marital relationship.

**(2)** An Employee's Domestic Partner. The Plan Administrator may require documentation proving a legal Domestic Partner relationship.

An individual is considered a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

**(a)** The Employee and individual are mentally competent to enter into a legally binding contract.

**(b)** The Employee and individual are at least 18 years of age and old enough to enter into marriage according to the laws of the state in which they reside.

**(c)** The Employee and the individual are not married to anyone, and if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased.

**(d)** The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

**(e)** The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole Domestic Partner. Each of the foregoing characteristics of the Domestic Partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the coverage is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

**(f)** The Employee and the individual are not in the domestic partnership solely for the purpose of obtaining benefits.

The Employee and the individual must have a signed and notarized Affidavit of Domestic Partnership and **at least two of the following items**:

- A joint mortgage or lease agreement;
- A notarized mutual assignment of Power of Attorney for financial and medical purposes;
- A joint checking or credit account;
- A formal commitment ceremony document, which is subject to validation;
- A primary beneficiary designation for will, life insurance and/or retirement benefits.

To obtain more detailed information or to apply for this coverage, the Employee must contact the Plan Administrator.

In the event the domestic partnership is terminated, either partner is required to inform the Plan Administrator of the termination of the partnership.

**(3)** An Employee's child(ren). The Plan Administrator may require documentation of the child's eligibility for coverage under the Plan.

An Employee's "child" includes their:

**(a)** natural child.

**(b)** stepchild (as long as the natural parent remains married to the Employee and also resides in the Employee's household).

**(c)** adopted child or a child placed for adoption with the Employee in anticipation of adoption. A child of a Domestic Partner is eligible only when such child is legally adopted by the Employee.

The phrase "child placed for adoption with the Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

**(d)** child for whom the Employee is appointed Legal Guardian.

**(e)** child who is an alternate recipient under a Qualified Medical Child Support Order. See "Qualified Medical Child Support Order" below for details.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

**(f)** natural child, stepchild, adopted child, or child for whom the Employee is appointed Legal Guardian, as described above, who is age 26 or over and Totally Disabled on the date of enrollment, provided such child's Total Disability commenced prior to their attaining age 26. The Employee must remain enrolled in the Plan and the additional contributions, if any, must be paid for the Totally Disabled child to be covered.

An Employee's child will be considered an eligible Dependent from birth until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month, unless such child is Totally Disabled on that date, in which case, coverage may be continued if Plan requirements are met (see below). Proof of Total Disability, as well as proof of continued Total Disability may be required from time to time.

If the coverage of a Dependent child is predicated on the individual being a full-time student, coverage will not end if the Dependent child is unable to maintain full-time student status due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the Dependent child's treating Physician certifies in writing that the Dependent child is suffering from a serious or catastrophic Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the Dependent child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully-insured), if the changed coverage continues to provide coverage for Dependent children. However, this extension does not extend coverage beyond the date that a Dependent child's fails to meet the Dependent eligibility requirements other than the requirement to be a full-time student, such as attaining the maximum age under the Plan. Except for a student who is on a Medically Necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

With regard to a Totally Disabled Dependent child, within 31 days of a Totally Disabled child becoming newly-enrolled or reaching the limiting age, the Employee shall provide the Plan Administrator with documentation from the child's attending Physician pertaining to the child's Total Disability. The Plan must approve the request for coverage under this provision of the Plan in order for coverage to become effective or remain in effect. A Totally Disabled child must satisfy all of the following conditions:

- The child is Totally Disabled. "Totally Disabled" or "Total Disability" means the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or is expected to last for at least 12 continuous months;

- The child has the same principal place of residence as the Employee or for more than one-half of the taxable year during which eligibility is continued. (An individual who does not reside with the taxpayer because of a temporary absence is treated as residing with the taxpayer. For example, a nonpermanent failure to occupy the same residence by reason of illness, education, business, vacation, military service, institutionalized care for a child who is Totally Disabled, or incarceration may be treated as a temporary absence because of special circumstances);

- The child does not provide over one-half of their own support for the taxable year; and

- The child does not file a joint return with their spouse for the taxable year.

The Plan Administrator may require, at reasonable intervals, subsequent proof of the child's Total Disability and dependency, generally not more than once each year; however, if the child's condition is such that there may be improvement significant enough to affect the child's eligibility under the Plan, the Plan Administrator reserves the right to require more-frequent evaluation, or to have the Dependent child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of Total Disability.

If the Employee has questions about whether their Dependent child qualifies as a tax dependent for purposes of the Plan, the Employee is strongly encouraged to contact their personal tax advisor for assistance.

A Spouse or Domestic Partner or a Dependent child, as described above, may be enrolled as an Employee or a Dependent, but not as both. In the event Employees who are married to each other elect to be covered as Employees, their children will be covered as Dependents of one Spouse or Domestic Partner, but not of both.

In the event a child's unmarried parents are Employees, the child may be covered as a Dependent of one parent or the other, but not of both.

**Eligible Classes of Retired Employee's Dependents.** A Retired Employee's Dependent is considered any one of the following persons:

**(1)** A Retired Employee's Spouse:

**(a)** who was enrolled in the Plan on or before the date the Employee retired. The Plan Administrator may require documentation of continued eligibility; or

**(b)** who is newly-acquired as a result of marriage. The Plan Administrator may require documentation proving a legal marital relationship.

**(2)** A Retired Employee's child(ren). The Plan Administrator may require documentation of the child's eligibility for coverage under the Plan.

A Retired Employee's "child" includes their:

**(a)** child who was enrolled in the Plan as the Employee's eligible Dependent child on or before the date the Employee retired.

**(b)** natural child;

**(c)** stepchild (as long as the natural parent remains married to the Retired Employee and also resides in the Retired Employee's household).

**(d)** adopted child or a child placed for adoption with the Retired Employee in anticipation of adoption.

The phrase "child placed for adoption with the Retired Employee in anticipation of adoption" refers to a child whom the Retired Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

**(e)** child for whom the Retired Employee is appointed Legal Guardian.

**(f)** child who is an alternate recipient under a Qualified Medical Child Support Order. See "Qualified Medical Child Support Order" below for details.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

**(g)** natural child, stepchild, adopted child, or child for whom the Retired Employee is appointed Legal Guardian, as described above, who is age 26 or over and Totally Disabled on the date of enrollment, provided such child's Total Disability commenced prior to their attaining age 26. The Retired Employee must remain enrolled in the Plan and the additional contributions, if any, must be paid for the Totally Disabled child to be covered.

A Retired Employee's child will be considered an eligible Dependent from birth until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Retired Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month, unless such child is Totally Disabled on that date, in which case, coverage may be continued if Plan requirements are met (see below). Proof of Total Disability, as well as proof of continued Total Disability may be required from time to time.

If the coverage of a Dependent child is predicated on the individual being a full-time student, coverage will not end if the Dependent child is unable to maintain full-time student status due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the Dependent

child's treating Physician certifies in writing that the Dependent child is suffering from a serious or catastrophic Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the Dependent child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully-insured), if the changed coverage continues to provide coverage for Dependent children. However, this extension does not extend coverage beyond the date that a Dependent child's fails to meet the Dependent eligibility requirements other than the requirement to be a full-time student, such as attaining the maximum age under the Plan. Except for a student who is on a Medically Necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

With regard to a Totally Disabled Dependent child, within 31 days of a Totally Disabled child becoming newly-enrolled or reaching the limiting age, the Retired Employee shall provide the Plan Administrator with documentation from the child's attending Physician pertaining to the child's Total Disability. The Plan must approve the request for coverage under this provision of the Plan in order for coverage to become effective or remain in effect. A Totally Disabled child must satisfy all of the following conditions:

- The child is Totally Disabled. "Totally Disabled" or "Total Disability" means the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or is expected to last for at least 12 continuous months;

- The child has the same principal place of residence as the Retired Employee for more than one-half of the taxable year during which eligibility is continued. (An individual who does not reside with the taxpayer because of a temporary absence is treated as residing with the taxpayer. For example, a nonpermanent failure to occupy the same residence by reason of illness, education, business, vacation, military service, institutionalized care for a child who is Totally Disabled, or incarceration may be treated as a temporary absence because of special circumstances);

- The child does not provide over one-half of their own support for the taxable year; and

- The child does not file a joint return with their spouse for the taxable year.

The Plan Administrator may require, at reasonable intervals, subsequent proof of the child's Total Disability and dependency, generally not more than once each year; however, if the child's condition is such that there may be improvement significant enough to affect the child's eligibility under the Plan, the Plan Administrator reserves the right to require more-frequent evaluation, or to have the Dependent child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of Total Disability.

If the Retired Employee has questions about whether their Dependent child qualifies as a tax dependent for purposes of the Plan, the Retired Employee is strongly encouraged to contact their personal tax advisor for assistance.

A Spouse or a Dependent child, as described above, may be enrolled as a Retired Employee or a Dependent, but not as both. In the event Retired Employees who are married to each other elect to be covered as Retired Employees, their children will be covered as Dependents of one of the Spouses, but not of both.

In the event a child's unmarried parents are Employees, the child may be covered as a Dependent of one parent or the other, but not of both.

**Qualified Medical Child Support Order.** The term "Qualified Medical Child Support Order" means an order that creates or recognizes a child's right to receive Plan benefits. The term "Qualified Medical Child Support Order" also includes a National Medical Support Notice (NMSN) that the Plan determines to be qualified. A support order may be issued by a state court or through a state administrative process. When the Plan Administrator receives a Medical Child Support Order identifying a child as having the right to enroll in the Plan, the Plan Administrator will notify both the Employee or Retired Employee and the child that the order has been received. The notification from the Plan Administrator will also indicate the procedure for determining whether the Medical Child Support Order is qualified.

To be considered a Qualified Medical Child Support Order, the order must clearly specify all of the following:

**(1)** The Employee's or Retired Employee's name and last known mailing address.

**(2)** The name and mailing address of the child specified in the order.

**(3)** A reasonable description of the type of coverage to be provided to the child, or the manner in which the type of coverage will be determined.

**(4)** The period to which the order applies.

**(5)** The name of the plan to which the order applies.

The Plan Administrator or its designee will notify the Employee or Retired Employee whether or not the child is eligible for coverage within 31 days of receipt of the order. If the Employer offers more than one plan option, the child will be enrolled in the same plan in which the Employee or Retired Employee is enrolled. The Dependent child's eligibility for enrollment will be under the same terms and conditions as other Dependents. The Plan Administrator is not required to obtain approval from the Employee or Retired Employee to add the child to the Plan. Dependent children covered under a Qualified Medical Child Support Order who reside in an area not served by the network used by the Employee or Retired Employee will receive the same benefit levels as the Employee or Retired Employee when utilizing Preferred Providers in the Dependent's designated service area provided the Dependent child follows the Plan's requirements.

The child may designate another person, such as a custodial parent or Legal Guardian, to receive the Plan, reimbursement for claims, explanation of benefit forms and other Plan-related materials.

If the Plan Administrator determines that the order is not a Qualified Medical Child Support Order, each child specified in the order as being entitled to enroll in the Plan may submit a written appeal to the Plan Administrator. The Plan Administrator is required to respond in writing within 31 days of receiving the appeal.

The Employer will not disenroll or eliminate coverage of any such child until any of the following apply:

- Satisfactory written evidence is provided that the order is no longer effective.
- Comparable coverage through another plan will take effect no later than the disenrollment date.
- The Plan Sponsor eliminates Dependent coverage for all Covered Persons.
- The Plan Sponsor terminates the Plan for all Covered Persons.
- Or for reasons otherwise specified in the "TERMINATION OF COVERAGE" section.

Enrollment of a Dependent child in response to a Qualified Medical Child Support Order must be made according to the specifications of the order, without regard to normal enrollment dates. Copies of the Plan's procedures governing Qualified Medical Child Support Orders and a sample Qualified Medical Child Support Order may be obtained without charge by contacting the Plan Administrator or the Third Party Administrator whose phone numbers can be found in the in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.

**Tax Treatment for Certain Dependents.** Federal tax law generally does not recognize legally-separated or former Spouses, or Domestic Partners, as dependents under the federal tax code unless the Spouse or partner otherwise qualifies as a dependent under the Internal Revenue Code § 152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be enrolled in the Plan as eligible Dependents, as additional income to the Employee or Retired Employee. Neither the Employer/Plan Sponsor nor the Third Party Administrator provide tax advice. The Employee or Retired Employee is responsible for understanding the tax consequences for all dependents they enroll in the Plan.

**Persons Excluded as Dependents.** The following persons are excluded as Dependents under the Plan:

**(1)** Other individuals living in the Employee's or Retired Employee's home, but who are not eligible as defined;

**(2)** The legally separated or divorced former Spouse of the Employee or Retired Employee;

**(3)** A Domestic Partner from whom the Employee is legally separated or has received a dissolution of the domestic partner relationship.

**(4)** A domestic partner of a Retired Employee.

**(5)** A Spouse or Dependent child who is on active duty in any military service of any country;

**(6)** A Spouse or Dependent child who is enrolled in the Plan as an Employee or Retired Employee;

**(7)** Grandchild(ren), unless the child is adopted or placed for adoption with the Employee or Retired Employee or the Employee or Retired Employee is appointed Legal Guardian; and

**(8)** Foster child(ren), unless the Employee or Retired Employee is appointed Legal Guardian.

**Eligibility Requirements for Dependent Coverage.** Subject to all Plan provisions and limitations, a family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. An Employee must enroll each Dependent for coverage before that Dependent's coverage takes effect.

**PLEASE NOTE:** At any time, the Plan may require proof that a Dependent qualifies or continues to qualify as a Dependent as defined by the Plan. For a new Employee's Dependent, an existing Employee's Dependent who experiences a qualifying change-in-status event, or a new Dependent who enrolls in the Plan during an Open Enrollment period, proof of Dependent eligibility must be provided to the Employer within 60 days of enrollment of such Dependent on the Plan.

**Enrollment Requirements for Eligible Dependent Children.**

- **Newborns:** A newborn child must be enrolled within 31 days of birth by completing the enrollment material or process established by the Employer. A newborn child of an Employee or Retired Employee who has Dependent coverage is not automatically enrolled in the Plan. If the newborn child is not enrolled in the Plan on a timely basis, the newborn will be considered a Late Entrant. See "TIMELY ENROLLMENT, LATE ENROLLMENT AND OPEN ENROLLMENT—Timely Enrollment" below.

  A newborn of a Dependent child is eligible for coverage only if the grandparent (the Employee or Retired Employee) adopts the newborn, the newborn is placed for adoption with the grandparent, or the grandparent is the newborn's Legal Guardian.

- **Adopted children, children placed for adoption or children under legal guardianship:** If an Employee or Retired Employee adopts a child, serves as a child's Legal Guardian, or a child is adopted or placed for adoption with an Employee or Retired Employee, Plan coverage is subject to completion of the enrollment material or process established by the Employer, including but not limited to the submission of written documentation, including the signature of the judge on a final order of adoption, guardianship or placement for adoption, within

31 days from the date of the order or agreement. Written documentation includes, but is not limited to, an interim court order, an agreement of placement for adoption or the signature of a judge on a final order of adoption, guardianship or placement for adoption. When a legal document is required to determine or verify eligibility of a dependent, the entire document must be provided, including subsequent declarations, judgments, amendments thereto, and relevant signatures.

If the adoption of a child who is placed for adoption with the Employee or Retired Employee is not finalized, the child's coverage under the Plan will terminate when the child's adoptive placement with the Employee or Retired Employee terminates.

Contributions for the cost of coverage for the newborn, adopted child or child placed for adoption with the Employee or Retired Employee must be paid within 31 days from the date the enrollment material or process established by the Employer is completed. For details on completion of the enrollment material or process established by the Employer, contact The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

The "Continuation Coverage Rights under COBRA" provisions of the Plan will not be applicable to a newborn child or adopted child who is not enrolled in the Plan, except in the case of a properly-enrolled child who is born to or placed for adoption with the COBRA qualified beneficiary during a period of COBRA continuation coverage.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the eligibility requirements are met; all enrollment requirements are met; and the Employee is enrolled in the Plan.

**TIMELY ENROLLMENT, LATE ENROLLMENT AND OPEN ENROLLMENT**

**(1)** **Timely Enrollment.** An enrollment is considered "timely" if the completed enrollment material or process is dated no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are married to each other are enrolled in the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Employee with no Waiting Period as long as coverage has been continuous.

**(2)** **Late Enrollment.** An enrollment is considered "late" if it is not made on a "timely basis". If the Employee does not complete the enrollment material or process established by the Employer within 31 days of their initial eligibility date or Special Enrollment Period event, or they decline coverage and later decide to enroll, the Employee and their eligible Dependents will not be able to enroll for Plan coverage until the next Open Enrollment period, or unless a qualifying change-in-status event occurs.

The late enrollment provisions do not apply to Retired Employees who did not enroll for retiree coverage on the date of their retirement and their Dependents.

**(3)** **Open Enrollment.** During the annual Open Enrollment period held by the Plan Administrator each November, eligible Employees and their Dependents will have the opportunity to enroll in or make other changes under the Plan by following the process established by the Plan Administrator. Individuals who are considered Late Entrants will also have the opportunity to enroll in the Plan. Open Enrollment is available to COBRA participants to the extent required by applicable law subject to all Plan provisions and limitations pertaining to such enrollment.

Benefit and coverage choices made during the Open Enrollment period will become effective on the first day of the new Benefit Period and will remain in effect until the beginning of the next Benefit Period unless a Special Enrollment event or a change in family status (see the "CHANGE-IN-STATUS EVENTS" subsection below) occurs during the year.

During the annual Open Enrollment period, the only available option for a Retired Employee is to elect to discontinue coverage for themselves and/or their Dependents. See also "Retired Employee Coverage Details" in the "RETIRED EMPLOYEE COVERAGE: ELIGIBILITY AND EFFECTIVE DATES" section.

An individual who fails to make a benefits and/or coverage election during the annual Open Enrollment period will automatically retain their present benefits and coverage. However, the Plan Administrator has the discretion to require an affirmative Open Enrollment election, any requirements of which the Plan Administrator, or its designee, will communicate to Employees and Retired Employees.

Eligible individuals will receive detailed information regarding Open Enrollment from the Plan Administrator.

**SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under certain circumstances. If an Employee declines enrollment for themselves or their Dependents (including their Spouse or Domestic Partner) because of other health insurance or group health plan coverage, there may be a right to enroll in the Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). In addition, in the case of a birth, marriage, registration of a Domestic Partner relationship, adoption or placement for adoption, there may be a right to enroll in the Plan. A request for enrollment in the Plan due to a Special Enrollment event must be made within the timeframe(s) specified in the "Special Enrollment Periods" subsection below. Special Enrollment is available to COBRA participants to the extent required by applicable law subject to all Plan provisions and limitations pertaining to such enrollment. Special Enrollment is available to COBRA participants to the extent required by applicable law subject to all Plan provisions and limitations pertaining to such enrollment. Based on applicable law, in all cases involving a loss of coverage Special Enrollment event, Retired Employees and their Dependents are not entitled to Special Enrollment.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

**SPECIAL ENROLLMENT PERIODS**

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

**(1)** **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in the Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:

**(a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the individual. Special Enrollment rights do not apply to Retired Employees and their Dependents in this situation.

**(b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment. Special Enrollment rights do not apply to Retired Employees and their Dependents in this situation.

**(c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for that coverage or because employer contributions towards that coverage were terminated. Special Enrollment rights do not apply to Retired Employees and their Dependents in this situation.

In this case, the Employee or Dependent must request enrollment in the Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions. Coverage under the Plan will begin no later than the first day of the first month following the date the enrollment material or process established by the Employer is completed.

For purposes of these rules, a "loss of eligibility" under the other coverage occurs if one of the following occurs:

**(i)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

**(ii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, dissolution of the Domestic Partner relationship, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

**(iii)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

**(iv)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right under the Plan.

**(2) Acquiring a newly-eligible Dependent may create a Special Enrollment right.** If:

**(a)** the Employee is a participant under the Plan (or is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period) or the Retired Employee is a participant under the Plan, and

**(b)** a person becomes a Dependent of the Employee or Retired Employee through marriage, registration of a Domestic Partner relationship, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under the Plan.

In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the Employee or Retired Employee may be enrolled as a Dependent of the Employee or Retired Employee if the Spouse or Domestic Partner is otherwise eligible for coverage. If the Employee is not enrolled in the Plan at the time of the event, the Employee must enroll under this Special Enrollment Period in order for their eligible Dependents to enroll. If the Retired Employee is not enrolled in the Plan at the time of the event, their Dependent is not eligible for enrollment under the Plan.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, registration of a Domestic Partner relationship, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of an Employee and/or a Dependent enrolling in the Plan during a Special Enrollment Period will be effective as follows:

**(i)** In the case of marriage, as of the date of the marriage, or

**(ii)** In the case of a Domestic Partner relationship, as of the date of the registration of the Domestic Partner relationship,

**(iii)** In the case of a Dependent child's birth, as of the date of birth; or

**(iv)** In the case of a Dependent child's adoption or placement for adoption, the date of the adoption or placement for adoption. A child of a Domestic Partner is eligible for coverage only when

such child is legally adopted by the Employee.

**(3)** **Eligibility changes in Medicaid and State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in the Plan, may enroll if:

**(a)** The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Plan (SCHIP) under Title XXI of such Act and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage.

The Employee or Dependent must request enrollment in the Plan within 60 days after such Medicaid or SCHIP coverage is terminated.

**(b)** The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to the Plan through a Medicaid or SCHIP plan (including any waiver or demonstration project conducted with respect to such plan).

The Employee or Dependent must request enrollment in the Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage under the Plan will become effective as of the first day of the first month following the date the enrollment material or process established by the Employer is completed unless an earlier date is established by the Employer or by regulation.

To learn more about these Medicaid and SCHIP plans, contact your state Medicaid or SCHIP office or dial (877) KIDS NOW ((877) 543-7669) or visit the website at www.insurekidsnow.gov.

**CHANGE-IN–STATUS EVENTS**

In addition to the Special Enrollment rights granted under HIPAA, the Plan allows for certain additional election changes. Upon enrollment in the Plan, coverage remains in effect through the end of the Benefit Period unless there is a change-in-status event as described below. Unless otherwise indicated, an Employee must contact The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section within 31 days after a change-in-status event occurs. In the event of a status change involving a new Spouse or Dependent child, other family members also may be eligible to enroll. Supporting documentation may be required. A change-in-status event includes all of the following, provided that the event affects the eligibility for coverage under the Plan or another employer's plan:

- The Employee, the Employee's or Retired Employee's Spouse, the Employee's Domestic Partner, or the Employee's or Retired Employee's Dependent child, experience a change in employment status that affects eligibility for benefits (e.g., termination or commencement of employment, or a change from part-time to full-time or full-time to part-time employment).

- The Employee's legal marital status changes due to legal separation, marriage, divorce, dissolution of domestic partner relationship, annulment or the death of their Spouse or Domestic Partner.

- A child is born, legally adopted or placed for adoption; the Employee or Retired Employee is appointed as Legal Guardian to a child; the Employee or Retired Employee is legally determined to be the parent of a child;

- The Employee, the Employee's Spouse's, the Employee's Domestic Partner's or the Employee's Dependent child's hours of employment are reduced or increased.

- An event occurs that causes the Employee's or Retired Employee's Dependent child to satisfy or stop

satisfying the eligibility requirements of the Plan, such as reaching the limiting age, change in Total Disability status, or any similar circumstance.

- The Employee, the Employee's or Retired Employee's Spouse's, the Employee's Domestic Partner's, or the Employee's or Retired Employee's Dependent child's place of residence changes, which significantly affects the availability of Preferred Providers.

- If the individual is an Active Employee and previously declined coverage under the Plan because they were covered under another employer's group health plan, and they lose coverage under that group health plan (for reasons other than failing to pay the premium or misrepresentation), that plan terminates or the employer sponsoring that plan ceases to make contributions.

- If the individual is an Active Employee, and they previously declined coverage under the Plan because COBRA continuation coverage was in effect, and they have exhausted their COBRA continuation coverage period.

- The Employee or Retired Employee is required to provide health care coverage for their Dependent child pursuant to a Qualified Medical Child Support Order.

- The Employee, the Employee's Spouse, the Employee's Domestic Partner or the Employee's Dependent child(ren) enrolls in or ends coverage under Medicare or Medicaid (if the loss of Medicaid coverage is involuntary, a request for enrollment under the Plan must be made within 60 days of the date of the loss of coverage).

- The Employee, the Employee's Spouse, the Employee's Domestic Partner or the Employee's Dependent child(ren) lose coverage under a State Child Health Insurance Program (SCHIP); A request for enrollment under the Plan must be made within 60 days of the date of the loss of coverage.

- The Employee, the Employee's Spouse, the Employee's Domestic Partner or the Employee's Dependent child(ren) become eligible for state premium assistance through Medicaid or a State Child Health Insurance Program (SCHIP). A request for enrollment under the Plan must be made within 60 days of the date the Employee, the Employee's Spouse or the Employee's Dependent child(ren) are determined eligible for such assistance.

- Changes due to enrollment in a federal or state exchange plan ("Marketplace"); An Employee may prospectively revoke coverage under the Plan which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions (for revocation due to enrollment in a qualified health plan) are met:

    - The Employee is eligible for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and

    - The revocation of the election of coverage under the Plan corresponds to the intended enrollment of the Employee and any related individuals who cease coverage due to the revocation in a qualified health plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

    The Plan Administrator may rely on the reasonable representation of an Employee who has an enrollment opportunity for a qualified health plan through a Marketplace that the Employee and related individuals have enrolled or intend to enroll in a qualified health plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

If a change-in-status event occurs, the Employee or Retired Employee may change elections during the Benefit Period and make a new election for the remaining portion of the Benefit Period only if the new election is on account of, and corresponds with, a change-in-status event that affects eligibility for coverage under the Plan. A change-in-status

event that affects eligibility under the Plan includes a change in status that results in an increase in the number of Dependents. Plan coverage will become effective as of the date of the change-in–status event.

**TERMINATION OF COVERAGE**

**When Employee Coverage Terminates.** An Employee's coverage will terminate on the earliest date determined by the Employer (In certain circumstances, an Employee may be eligible for COBRA continuation coverage. For an explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section titled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."). The termination of coverage date is based on the following:

**(1)** The date on which the Plan is amended and the Employee is no longer eligible, or terminated.

**(2)** The date on which the Employee's Eligible Class is eliminated.

**(3)** The end of the pay period following the last date of the Employee's employment with the Employer.

**(4)** The date on which an Employee is on disability, medical leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

**(5)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**(6)** The date of the Employee's death.

**(7)** If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Plan Administrator may either void coverage for the Employee and Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator will provide at least 30-days' advance-written notice of such action.

**Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff.** An Employee remains eligible for Plan coverage for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff, as follows:

- **For FMLA-protected medical leave of absence only:** The Employee will continue to be eligible under the medical and dental Plans for the time period that they are determined to be on a FMLA-protected medical leave of absence, subject to the following:
    - The Employee and/or their authorized representative must provide acceptable medical documentation as required in the discretion of the Plan Administrator.
    - Required contributions for Plan coverage must be paid on a timely basis.

  Eligibility for coverage will cease at the end of the FMLA-protected medical leave of absence, unless the Employee is granted additional leave. Extension of coverage will not exceed an additional 30 days. Upon the loss of coverage, the Employee will be eligible for COBRA continuation coverage (see the "CONTINUATION COVERAGE RIGHTS UNDER COBRA" section)

- **For unprotected or non-medical leave of absence only (non-FMLA):** Eligibility for coverage continues for the first 30 days of the leave. Eligibility for coverage ends after 30 days of unpaid non-FMLA leave of absence and the Employee will be eligible for COBRA continuation coverage (see the "CONTINUATION COVERAGE RIGHTS UNDER COBRA" section).

- **For layoff only:** The date the Employer ends the continuance pursuant to the terms of such layoff.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits change for others in the class, they will also change for the continued person.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under the Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and their Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue coverage under the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

**(1)** The maximum period of coverage for an Employee and their Dependents under such an election shall be the lesser of:

**(a)** The 24-month period beginning on the date on which the Employee's absence begins; or

**(b)** The day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.

**(2)** An Employee who elects to continue health plan coverage must pay up to 102 percent of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

**(3)** An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing coverage under USERRA as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for themselves and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Retired Employee Coverage Terminates.** A Retired Employee's coverage will terminate on the date determined by the Employer. The termination of coverage date is based on the following:

**(1)** The date on which the Plan is amended, and the Retired Employee is no longer eligible, or terminated.

**(2)** The date on which the Retired Employee's Eligible Class is eliminated.

**(3)** The date of the Retired Employee's death.

**(4)** The date on which the Retired Employee becomes eligible for Medicare (whether or not the Retired Employee enrolls in Medicare) or has reached the limiting age of 65.

**(5)** The date on which the Retired Employee voluntarily terminates coverage .

**(6)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**(7)** If a Retired Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Plan Administrator may either void coverage for the Retired Employee and their Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator will provide at least 30-days' advance-written notice of such action.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the date determined by the Employer (except in certain circumstances, a Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section titled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."). Reasons for termination of coverage include the following:

**(1)** The date on which the Plan or Dependent coverage under the Plan is terminated.

**(2)** The date on which the Employee's or Retired Employee's coverage under the Plan terminates for any reason, including death.

**(3)** The date on which a Spouse or Domestic Partner becomes divorced or has received a dissolution of the domestic partner relationship or becomes legally separated from the Employee.

**(4)** The date on which a Spouse becomes divorced or becomes legally separated from the Retired Employee.

**(5)** The date on which a Dependent of a Retired Employee becomes eligible for Medicare (reaches age 65).

**(6)** The last day of the month on which a Dependent child ceases to be a Dependent as defined by the Plan.

**(7)** The date on which the Retired Employee voluntarily terminates coverage.

**(8)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**(9)** If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Plan Administrator may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator will provide at least 30-days' advance-written notice of such action.

**Extension of Benefits.** If coverage under the Plan would otherwise terminate with respect to a Covered Person, without regard to the continuation of coverage provisions and limitations of the Plan, benefits under the Plan can nevertheless be extended under the specific circumstances specified in the Plan. Unless otherwise noted, any extension of benefits period provided pursuant to the Plan *shall postpone* the starting date for measurement of the maximum period available for continuation of coverage pursuant to the "CONTINUATION OF COVERAGE RIGHTS UNDER COBRA" section. A person for whom the Employer has a responsibility to provide coverage pursuant to contractual agreement or court order will be entitled to an extension of benefits only to the extent to which there is a legal requirement to provide such extension of benefits either based on applicable law, contractual agreement or court order.

# HEALTH ALLIANCE MEDICAL POLICY

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

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

The Medical Policy has been developed as a guide for determining Medical Necessity and is available for use by the Plan Administrator and its designee with regard to the administration of Plan benefits, including but not limited to, determinations of Medical Necessity. The Medical Policy provides the criteria that must be met before Plan benefits are provided for certain health care services. The Medical Policy is available on the Health Alliance website HealthAlliance.org and can be found by clicking "Menu", "Claims" and "Policies and Procedures", or a paper copy of a Medical Policy can be requested by contacting 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. (**NOTE:** When accessing the website, the Covered Person must log in as a member to view the Health Alliance Medical Policy.)

To understand the Plan benefits that are available and verify benefits and Preauthorization requirements prior to receiving services, call the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION", or customer service at the phone number on the Plan ID Card.

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

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

# MEDICAL BENEFITS

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

**Verification of Benefits.** 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, to verify Plan benefits before the expense is incurred.

**Nurse Contact for General Health Information.** In the case of an emergency, call 911. For non-emergency health questions, Covered Persons may call and speak with a nurse about general health information at the phone number specified in the "GENERAL PLAN INFORMATION" section or on the Plan ID Card.

Please Note: For information about Plan benefits, call 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.

**Medical Benefit Expenses.** Medical benefits, if determined to be Eligible Expenses, apply when expenses are incurred by a Covered Person for care and treatment of an Injury or Sickness and while the person is enrolled in the Plan.

Plan benefits are subject to the exclusions, limitations and requirements described more fully herein including, but not limited to:

**(1)** the determination that services, supplies and treatment are Medically Necessary;

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

**(3)** Benefits, if determined to be Eligible Expenses, are based on contract rates when using Preferred Providers and Extended Network Providers, and Maximum Allowable Charges when using Non-Preferred Providers.

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

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

**(2)** The Physician remains in the Covered Person's designated service area; and

**(3)** The Physician agrees to abide by the terms and conditions of the terminating contract unless otherwise approved by the Plan or its designee for Medical Necessity.

The Covered Person must 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, within 30 days of receiving the termination notice if continued care benefits with a terminating Physician are desired.

- **Ongoing course of treatment.** If a Covered Person is in an ongoing course of treatment, the continued treatment, if determined to be an Eligible Expense, will be considered at the Preferred Provider benefit level with that Physician for a period of 90 days. The 90-day period starts on the date the Covered Person learns that the Physician's contract is terminating.
- **Maternity care.** If a Covered Person is Pregnant and has entered week 13 of Pregnancy by the date of the Physician's termination, continued care, if determined to be an Eligible Expense, will be considered at the Preferred Provider benefit level with that Provider through post-partum care.

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

**Continued Care Benefits for New Covered Persons.** If the treating Physician is not a Preferred Provider for the Plan, a Covered Person may be eligible for benefits of continued treatment during a transitional period with that Physician if in an ongoing course of treatment or if Pregnant. The Physician must agree to accept reimbursement rates similar to other Preferred Providers for the Plan and comply with the Third Party Administrator's quality assurance requirements and policies and procedures. The Covered Person must 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, within 15 days of their effective date of coverage if continued care benefits with a Non-Preferred Physician are desired.

- **Ongoing course of treatment.** If a Covered Person is in an ongoing course of treatment, continued treatment, if determined to be an Eligible Expense, will be considered at the Preferred Provider benefit level with the treating Physician for a period of 90 days from their effective date of coverage.
- **Maternity care.** If a Covered Person is Pregnant and has entered week 13 of Pregnancy on their effective date of coverage, continued care, if determined to be an Eligible Expense, will be considered at the Preferred Provider benefit level with the treating Physician through post-partum care.

**OUT-OF-POCKET EXPENSES AND MAXIMUM BENEFITS**

**Copayment, Coinsurance and Deductible.** All Copayment, Coinsurance and Deductible amounts are specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Coinsurance for Preferred Providers is based on the amount the Preferred Provider has agreed to accept as full payment for the service, which is referred to as the discounted or allowed amount.

**Out-of-Pocket Maximum.** The Out-of-Pocket Maximum amounts for an individual and Family Unit are specified in the "SCHEDULE OF BENEFITS" section. These are the maximum amounts Covered Persons are required to pay in Copayments, Coinsurance and Deductibles for the Benefit Period for benefits, if determined to be Eligible Expenses. Once the Out-of-Pocket Maximum amounts are reached, the Plan will pay the remainder of Eligible Expenses incurred for the rest of the Benefit Period at 100 percent, unless otherwise stated herein. See the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section for items and services that do not apply to the Out-of-Pocket Maximums.

**Benefit Payment.** Each Benefit Period, benefits will be provided by the Plan for Eligible Expenses incurred by a Covered Person in excess of the Deductible amount, if applicable. Benefits will be considered at the appropriate benefit level as shown in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. No benefits will be provided in excess of the Benefit Period Maximum Benefit amount or any listed limits of the Plan.

**Maximum Benefits.** The Plan's Maximum Benefits are the total benefit amounts for a Covered Person and are specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. These are the Maximum Benefit amounts the Plan will pay for specific non-essential health benefits during the specified periods. Covered Persons must reimburse the Plan for any amounts exceeding the Maximum Benefits that the Plan pays on their behalf.

**STATUS CHANGE CARRYOVER (NO LOSS/NO GAIN)**

If a person enrolled in the Plan experiences an allowable status change, and the person is covered continuously under the Plan before, during and after the date of the status change, coverage will continue with regard to Deductible, Out-of-Pocket Maximum, and benefit accumulations as if the change in status did not occur:

- an active status to a COBRA status;

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- a COBRA status to an active status;
- a retired status to an active status;
- an employee to a dependent;
- a dependent to an employee;
- other allowable changes in status subject to all Plan provisions and limitations.

**BENEFITS**

This subsection describes the services, supplies and treatment for which benefits are available when they are determined to be Eligible Expenses. An expense is considered to be incurred on the date the service, supply or treatment is performed or furnished.

The Health Alliance Medical Policy has been developed as a guide for determining Medical Necessity and is available for use by the Plan Administrator and its designee with regard to the administration of Plan benefits, including but not limited to, determinations of Medical Necessity. See the "HEALTH ALLIANCE MEDICAL POLICY" section for more information.

- **Additional surgical opinion:**
  - A consultation with a board-certified surgeon when surgery is recommended.
  - A third opinion, if a second opinion does not confirm the primary surgeon's opinion.

- **Ambulance services:**
  - **Air transportation –** Emergency transportation by air ambulance for an Emergency Medical Condition. Air ambulance services are not considered Eligible Expenses when the Covered Person can be safely transported by ground ambulance or by means other than by ambulance.
  - **Ground Transportation –** Emergency transportation by ground ambulance for an Emergency Medical Condition.
  - The Plan will not provide benefits for long distance trips or for use of an ambulance because it is more convenient than other transportation.
  - 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 this "MEDICAL BENEFITS" section.

- **Bariatric surgery:**
  - Bariatric surgery for severe obesity for select gastric bypass procedures and laparoscopic adjustable gastric banding (LAGB) determined by the Plan or its designee to have significant published experience on long-term results for the treatment of severe obesity for patients who have documentation of participation in a Physician-supervised, integrated non-surgical weight loss program of at least six months duration within the last three years (minimum of four office visits during a six-month period) and who meet Medical Necessity criteria.
  - Subsequent related surgery to treat complications from an eligible surgery.
  - Subsequent surgery because of failure to achieve or maintain long-term weight loss may not be determined an Eligible Expense.
  - Benefits are limited to individuals age 18 and older at the time of surgery.
  - See also "Bariatric surgery-related services", "Cosmetic surgery" and "Obesity treatment and products" in the

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

"PLAN EXCLUSIONS" section.

- **Biologicals for the treatment of cancer:** Biologicals prescribed for the treatment of cancer when the biologicals are provided in accordance with an established protocol.
  - See also "Chemotherapeutics", "Chemotherapy" and "Radiation therapy" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Experimental treatments/procedures/drugs/devices/transplants" in the "PLAN EXCLUSIONS" section.

- **Blood:**
  - Blood, blood products and blood transfusions when ordered by a Physician.
  - Costs related to the administration and procurement of blood and blood components including the processing and storage of blood donated by the Covered Person for their own use.
  - See also "Blood processing" in the "PLAN EXCLUSIONS" section.

- **Chemotherapeutics:**
  - Chemotherapeutics prescribed for treatment when the chemotherapeutics are provided in accordance with an established protocol.
  - See also "Biologicals for the treatment of cancer", "Chemotherapy" and "Radiation therapy" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Experimental treatments/procedures/drugs/devices/transplants" in the "PLAN EXCLUSIONS" section.

- **Chemotherapy:**
  - Chemotherapy (including high-dose chemotherapy with bone marrow or peripheral stem cell transplantation) prescribed for treatment when the chemotherapy is provided in accordance with an established protocol.
  - See also "Biologicals for the treatment of cancer", "Chemotherapeutics" and "Radiation therapy" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Experimental treatments/procedures/drugs/devices/transplants" in the "PLAN EXCLUSIONS" section.

- **Chiropractic services:**
  - Chiropractic services, including Spinal Manipulation (and muscle manipulations), treatments, X-rays and other diagnostic services provided by a chiropractor or Physician.
  - Hot/cold pack therapy used in conjunction with approved manipulation and mobilization.
  - Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section.
  - See also "Massage therapy" in the "PLAN EXCLUSIONS" section.

- **Clinical trials:**
  - During an Approved Clinical Trial, routine patient costs for standard of care items and services typically provided absent a Clinical Trial unless the service or item is provided by the Clinical Trial directly.
  - For purposes of this subsection, "Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is approved or funded by a federally funded trial or a qualified non-

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

  - See also "Clinical trials" and "Experimental treatments/procedures/drugs/devices/transplants" in the "PLAN EXCLUSIONS" section.

- **Colorectal cancer screening:**
  - A screening for colorectal cancer for Covered Persons age 45–75, by means of a colonoscopy every 10 years or sigmoidoscopy once every five years, is included under the preventive care services benefit.
  - A follow-up colonoscopy after a positive fecal occult blood test including FIT (fecal immunochemical test) or at-home DNA stool test (e.g., Cologuard) when done within 160 days of the positive result is 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 also "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Complications of excluded treatments:** Care, services or treatment required as a result of complications from a treatment that is considered an exclusion under the Plan.

- **Contraceptive methods, procedures and services:**
  - Devices and the medical fitting and insertion of devices for Contraceptive purposes only are included under the preventive care services benefit. This includes, but is not limited to, IUD's, diaphragms, cervical caps and Contraceptive implants.
  - Injectables and the injection intended for Contraceptive purposes only are included under the preventive care services benefit. This includes, but is not limited to, DepoProvera®.
  - Female sterilization procedures intended for Contraceptive purposes only are included under the preventive care services benefit. (See also "Sterilization procedures" in this "MEDICAL BENEFITS—BENEFITS" section.)
  - See also "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section, and the "ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE 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.

- **Dental services:** Hospitalization for dental work for Dependent children age six and under, Covered Persons with a medical condition that requires hospitalization or general anesthesia for dental care, or Covered Persons who are disabled.
  - See also "Oral surgery" in this "MEDICAL BENEFITS—BENEFITS" section and "Dental services" in the "PLAN EXCLUSIONS" section.

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- **Diabetic equipment and supplies:**
  - The following diabetic equipment and supplies when ordered by a Physician:
    - blood glucose monitors;
    - blood glucose monitors for the legally blind;
    - insulin infusion device cartridges for the legally blind; and
    - lancets and lancing devices
  - Benefits are subject to the Durable Medical Equipment and orthopedic appliance Coinsurance amounts shown in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - See also the "PRESCRIPTION DRUG BENEFITS" section for other diabetic-related equipment and supplies.

- **Diabetic self-management training and education:** Outpatient self-management training and education for the treatment of types 1 and 2 diabetes and gestational diabetes mellitus.

- **Diagnostic testing:**
  - Including, but not limited to X-ray examinations, medical imaging, laboratory tests and pathology services when ordered by a Physician.
  - A three-dimensional (3D) *diagnostic* mammogram (breast tomosynthesis). A 3D *screening* mammogram is included under the preventive care services benefit.

- **Dressings and supplies:** Dressings, splints, casts and related supplies when administered by a Physician or by a nurse or other health care professional under the direction of a Physician.

- **Durable Medical Equipment and orthopedic appliances:**
  - Corrective and orthopedic appliances (such as leg braces and knee sleeves) and Durable Medical Equipment for home use (such as wheelchairs, surgical beds and oxygen equipment) when due to an Injury, Illness or medical condition.
  - Ostomy supplies, but not other disposable supplies.
  - Effective January 1, 2023: One home blood pressure monitor/cuff combination (A4670), and an additional XL cuff (A4663) if required, every five years:
    - Benefits will be provided for the following Covered Persons only with no Preauthorization required:
      - Individuals with a diagnosis of elevated blood pressure, without diagnosis of hypertension (diagnosis code R03.0); and
      - Individuals who have an encounter for screening for cardiovascular disorders (diagnosis code Z13.6).
  - Items and supplies must be prescribed by a Physician.
  - The Plan or its designee determines if the equipment is made available through rental or purchase agreements.
  - Costs associated with the repair of eligible equipment if the Plan or its designee determines the equipment has been properly maintained.
  - See also "Preventive care services", "Orthotics", "Prostheses", and "Reconstructive surgery" in this "MEDICAL BENEFITS—BENEFITS" section for other DME-related items.
  - See also "Disposable items", "Durable Medical Equipment, orthopedic appliances and devices" and "Hearing

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devices and related services" in the "PLAN EXCLUSIONS" section.

- To be consistent with changes in medical technology, the Third Party Administrator maintains a list of eligible and excluded items and the maximum amount payable under this benefit. Benefits can be verified by calling the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.

- **Emergency Services:**
  - Emergency Services received for an Emergency Medical Condition.
  - If Emergency Services are subject to a Copayment, the Copayment is waived if the Covered Person is admitted to the Hospital.
  - Emergency Services when received outside the United States of America, provided the Covered Person did not travel to such location for the purpose of receiving medical services, drugs or supplies.
  - Care required to treat and stabilize an Emergency Medical Condition when received from a Non-Preferred Provider will be considered at no greater expense to the Covered Person than if the service had been provided by a Preferred Provider.
  - See also "Emergency Admission Notification" in the "PREAUTHORIZATION" section for details on required notification for emergency Hospital admissions.
  - See also "Urgent care" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Foreign travel" in the "PLAN EXCLUSIONS" section.
  - 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 this "MEDICAL BENEFITS" section.

- **Gender affirmation services and treatment:** The following gender affirmation services and treatment when ordered by a Provider or Physician:
  - Psychotherapy;
  - Pre-and-post-surgical hormone therapy; and
  - Gender affirmation surgery/ies, subject to Preauthorization by the Utilization Review Manager. The surgery must be performed by a qualified Provider. Gender affirmation surgery(ies) may be considered Medically Necessary when **all** of the following criteria are met:
    - The Covered Person is greater than or equal to age 18 years; and
    - The Covered Person has the capacity to make a fully informed decision and to consent for treatment; and
    - The individual has been diagnosed with the gender dysphoria, including **all** of the following:
      - **(i)** The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; and
      - **(ii)** The Covered Person's transgender identity has been present persistently for at least two years; and
      - **(iii)** The dysphoria is not a symptom of another Mental Health Disorder or a chromosomal abnormality; and
      - **(iv)** The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
    - The Covered Person is an active participant in a recognized gender identity treatment program and demonstrates **all** of the following conditions:
      - **(i)** The Covered Person has successfully lived and worked within the desired gender role full-time for

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at least 12 months (real life experience) without returning to the original gender; and

**(ii)** For breast surgery:

- Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); and
- One referral from a qualified mental health professional with written documentation submitted to the Physician performing the breast surgery; and

**(iii)** For genital surgery:

- Documentation of at least 12 months of continuous hormonal sex affirmation therapy, (unless medically contraindicated or Covered Person is unable or unwilling to take hormones)(may be simultaneous with real life experience); and
- Two referrals from qualified mental health professionals who have independently assessed the Covered Person. If the first referral is from the Covered Person's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent* (*At least one letter must be a comprehensive report.); and
- Separate evaluation by the Physician performing the genital surgery.

- Other services and procedures may be subject to reasonable medical management processes including, but not limited to Preauthorization. Contact the Utilization Review Manager to determine if Preauthorization applies to your situation.

- **Gynecomastia treatment:** Expenses incurred for services and supplies received for the treatment of gynecomastia.

- **Hearing evaluations:** Hearing evaluations when provided by a licensed audiologist..
  - See also "Hearing devices and related services" in the "PLAN EXCLUSIONS" section.

- **Home health care:** Intermittent Skilled Nursing Care and skilled therapeutic home services for homebound Covered Persons when the services are given under the direction of a Physician.
  - Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section.

- **Home infusion services:** Home infusion services, including medication and supplies, when given under the direction of a Physician.
  - See also "Chemotherapy" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Hospice care:**
  - Care, services and supplies provided under a Hospice Care Program when ordered by a Physician.
  - A Hospice Care Program must meet the following requirements:
    - It must be licensed by the laws of the jurisdiction where it is located and must be operated as a hospice as defined by those laws.
    - It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their Illness and, as estimated by a Physician, are expected to live less than 12 months as a result of that Illness.
    - It must be administered by a Hospital, home health agency or other licensed facility.
  - For purposes of this subsection, "Hospice Care Program" means a coordinated, interdisciplinary program for

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meeting the special physical, psychological, spiritual and social needs of a terminally ill Covered Person and their family, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care.

- **Hospital care:**
  - Hospital care, including services, supplies, and Prescription Drugs and Specialty Prescription Drugs that are provided through the medical benefit, when hospitalization is ordered by a Physician.
  - Benefits are limited to a semi-private (two-bed) accommodation, unless a medical condition warrants otherwise.
  - See also "Mental Health Disorder/Substance Use Disorder services and treatment" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Human organ transplant services:**
  - Human organ transplants for non-experimental organ or tissue transplants and procedures, including bone marrow transplants and similar procedures, upon prior order and written referral of a Physician and upon the findings of a Medical Director that the recommended treatment is Medically Necessary and is not excluded from coverage under any other sections of the Plan.
  - Transplants must be performed at a facility approved by the Plan Administrator or its designee.
  - Benefits begin with the transplant evaluation prior to initiation of the organ or tissue transplant or procedures and through one year after transplant.
  - Office visit and Hospital care Copayments or Coinsurance apply as shown in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - Organ and tissue procurement. Organ and tissue procurement consists of removing, preserving and transporting the donated organ or tissue.
  - Transportation, lodging and meals for the transplant recipient and a companion for travel to and from the designated transplant center. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Mileage for each Medically Necessary trip to and from the transplant facility shall be reimbursed at the standard mileage rate issued by the Internal Revenue Service for the year in which the expense is incurred for medical travel. Eligible Expenses incurred for meals and lodging required during medical travel more than 50 miles (roundtrip) from the transplant recipient's home shall be reimbursed based on per diem allowances issued by the Internal Revenue Service for the period during which the expense is incurred.
  - See also "Human organ donor services and treatment" and "Human organ transplants" in the "PLAN EXCLUSIONS" section.

- **Infertility services:** See the "ADDENDUM: ENHANCED INFERTILITY SERVICES" section for details.
  - See also "Infertility services" in the "PLAN EXCLUSIONS" section.

- **Mandibular and maxillary osteotomy:** A mandibular or maxillary osteotomy only for significant functional problems that have not been corrected with dental and/or orthodontic treatment.
  - See also "Temporomandibular joint (TMJ) disorder treatment" in this "MEDICAL BENEFITS—BENEFITS" section.)

- **Maternity care:**
  - The maternity care benefit applies to all Covered Persons which includes all Dependent (defined).
  - Routine prenatal care, delivery and postnatal care.

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  - 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.
  - Gestational diabetes screening for Covered Persons 24 to 28 weeks Pregnant and those at high risk of developing gestational diabetes is included under the preventive care services benefit.
  - Lactation counseling and/or support and the rental or purchase of a breast pump during Pregnancy and through the postpartum period is included under the preventive care services benefit.
  - See also "Newborn care" and "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section, and the "ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS" section, for other maternity- and newborn-related services.

- **Medical social services:** Medical social services, including Hospital discharge planning and assistance in accessing community service agencies and other related services when required to cope with a medical condition.

- **Mental Health Disorder/Substance Use Disorder services and treatment:**
  - Inpatient and Outpatient treatment;
  - Electroconvulsive therapy treatment;
  - Crisis intervention; and
  - Acute inpatient Substance Use Disorder detoxification if determined by a Physician that Outpatient management is not medically appropriate. Treatment is considered medical and does not apply to the Substance Use Disorder services and treatment benefit until the patient is discharged from the Hospital or transferred to a Substance Use Disorder unit.
  - See also "Counseling" and "Self-inflicted Injury or Illness" in the "PLAN EXCLUSIONS" section.

- **Newborn care:**
  - Benefits for the newborn begin at the moment of birth only if the enrollment requirements of the Plan are met as specified in the "Enrollment Requirements for Eligible Dependent Children" subsection of the "ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS—DEPENDENT COVERAGE: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES" section.
  - Newborn care for Illness, Injury, congenital defects, birth abnormalities and premature birth, when the newborn is timely enrolled.
  - If timely enrolled, routine nursery care is included under the birth parent's Copayments, Coinsurance and Deductibles during the first five days following birth. Expenses incurred for a timely enrolled newborn whose birth parent is not enrolled in the Plan are subject to the applicable Copayments, Coinsurance and Deductibles specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. If the newborn is not timely enrolled, there will be no payment from the Plan and the parent(s) will be responsible for all costs.
  - See also "Maternity care" and "Reconstructive surgery" in this "MEDICAL BENEFITS—BENEFITS" section.

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- **Oral surgery:**
  - The following procedures:
    - Surgical removal of partial or fully impacted or un-erupted teeth, including wisdom teeth, in connection with orthodontic treatment.
    - Surgical removal of erupted teeth, involving tissue flap and bone removal.
    - Surgical removal of impacted teeth, including wisdom teeth.
    - Alveolectomy.
    - Stomatoplasty with ridge extension.
    - Excision of pericoronal gingiva.
    - Removal of palatal torus.
    - Removal of mandibular tori.
    - Excision of hyperplastic tissue.
    - Removal of cyst or tumor.
    - Incision and drainage of abscess.
    - Closure of oral fistula of maxillary sinus.
    - Re-implantation of tooth.
    - Frenectomy.
    - Suture of soft tissue Injury.
    - Sialolithotomy for removal of salivary calculus.
    - Closure of salivary fluids.
    - Dilation of salivary duct.
    - Sequestrectomy for osteomyelitis or bone abscess, superficial.
    - Maxillary sinusotomy for removal of tooth fragment or foreign body.
    - Treatment of traumatic Injury to sound natural teeth for Medically Necessary non-restorative services within 30 days of Injury.
    - Treatment of traumatic Injury to the jawbones or surrounding tissue within 30 days of the Injury.
  - Anesthesia, local anesthetic, X-rays and lab work performed in connection with an eligible oral surgery procedure.
  - See also "Dental services" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Dental services" in the "PLAN EXCLUSIONS" section.

- **Orthotics:**
  - Specially molded and custom-made orthotics when prescribed by a Physician.
  - Special shoe inserts for arch or foot support that are prescribed following an open surgical procedure on the bones, tendons, etc., of the foot or may be prescribed to avoid an open surgical procedure.
  - The Durable Medical Equipment and orthopedic appliances Coinsurance amounts shown in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section applies.
  - See also "Durable Medical Equipment and orthopedic appliances" in this "MEDICAL BENEFITS—BENEFITS" section for other DME/orthotic-related items.
  - See also "Durable Medical Equipment, orthopedic appliances and devices" and "Foot care" in the "PLAN EXCLUSIONS" section.

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- **Outpatient Specialty Prescription Drugs provided under the medical benefit:**
  - Outpatient Specialty Prescription Drugs provided under the medical benefit, subject to a prior written order by the Covered Person's Physician.
  - Benefits are subject to the Deductible, Coinsurance and Copayment amounts specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - See also the "PRESCRIPTION DRUG BENEFITS" section for details on Pharmacy Prescription Drugs and Specialty Prescription Drugs.

- **Outpatient Surgery and procedures:**
  - Outpatient Surgeries and procedures.
  - Surgical fees, facility fees, anesthesia charges and other related services, as required.
  - Outpatient Surgery Copayments, Coinsurance and Deductibles apply to any associated facility fee for a surgery or procedure.

- **Physician services:**
  - Diagnostic and treatment services for an Illness or Injury and preventive care services when provided by a Physician or under the supervision of a Physician, including recommended periodic health care examinations and well-child care services.
  - Physician services while hospitalized.
  - See also "Hospital care" and "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Podiatry services:** Podiatry services, including but not limited to services related to diabetes.
  - See also "Foot care" in the "PLAN EXCLUSIONS" section.

- **Preventive care services:** Recommendations and guidelines may be updated periodically based on changes made by the source agency or organization.
  - Health care services such as screenings, check-ups and patient counseling that are used to prevent Illnesses, disease, and other health problems, or to detect Illness at an early stage when treatment is likely to work best.
  - Benefits, if determined as Eligible Expenses, are available with no cost sharing required by the Covered Person when the services are obtained by 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.
  - Laboratory and X-ray services provided in diagnosing and treating a medical condition are included under the diagnostic testing 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).
  - Additional preventive care expenses/screenings/tests/visits are subject to the applicable Benefit Period

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Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- For a list of common preventive care services and associated procedure codes the Plan will consider, see the "ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS" section.
- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
  - For more information, visit the USPSTF's website at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendations.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
  - For more information, visit the Bright Futures website at: https://brightfutures.aap.org.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration (HRSA).
  - For more information, visit the HRSA's website at: https://www.hrsa.gov/womens-guidelines.
- Immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
  - For more information, visit the CDC website at: https://www.cdc.gov/vaccines/acip/.
- 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 "Contraceptive methods, procedures and services", "Maternity care", "Newborn care" and "Sterilization procedures" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Prostate-specific antigen tests:**
  - Annual digital rectal exams and prostate-specific antigen tests for the following Covered Persons:
    - Asymptomatic men age 50 and older;
    - African-American men age 40 and older; and
    - Men age 40 and older with a family history of prostate cancer, when authorized by a Physician.

- **Prostheses:**
  - Prosthetic devices, such as artificial limbs, due to an Illness or Injury. For purposes of this subsection, "prosthetic device" means a fabricated substitute for a diseased or missing part of the body such as a limb or an eye.
  - Prosthetic devices must be prescribed by a Physician.
  - The Durable Medical Equipment and orthopedic appliance Coinsurance amount shown in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section applies.
  - To be consistent with changes in medical technology, the Third Party Administrator maintains a list of eligible and excluded items and the maximum amount payable under this benefit. Benefits can be verified by calling

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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 "Durable Medical Equipment, orthopedic appliances and devices" and "Hair loss care and treatment" in the "PLAN EXCLUSIONS" section.

- **Radiation therapy:**
  - Radiation therapy for treatment when the radiation therapy is provided in accordance with an established protocol.
  - See also "Biologicals for the treatment of cancer", "Chemotherapeutics" and "Chemotherapy" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Experimental treatments/procedures/drugs/devices/transplants" in the "PLAN EXCLUSIONS" section.

- **Reconstructive surgery:**
  - Services to correct a functional defect resulting from an acquired and/or congenital disease or Injury.
  - Services performed to correct a seriously disfiguring condition resulting from accidental Injury or incident due to surgery; however, benefits are provided only if such condition has a major effect on appearance and the condition can be reasonably corrected by the surgery.
  - Correction of a congenital defect or birth abnormality of an enrolled newborn.
  - Benefits for reconstructive surgery or a prosthetic device following a mastectomy. Benefits for breast reconstruction include the following:
    - Reconstruction of the breast on which the mastectomy has been performed;
    - Reconstructive surgery of the other breast to produce a symmetrical appearance;
    - Prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas; and
    - Nipple and areola reconstruction, including nipple and areola repigmentation to restore the physical appearance of the breast.
  - See also "Durable Medical Equipment and orthopedic appliances", "Newborn care" and "Prostheses" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Cosmetic surgery" and "Durable Medical Equipment, orthopedic appliances and devices" in the "PLAN EXCLUSIONS" section.

- **Rehabilitation and Skilled Nursing Care—inpatient services:**
  - Inpatient Hospital care for rehabilitation and Skilled Nursing Care in a Skilled Nursing Facility with ongoing documentation of Medical Necessity.
  - Services include but are not limited to inpatient speech, occupational and physical therapies.
  - Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section.
  - See also "Custodial Care or convalescent care", "Institutional care" and "Speech therapy" in the "PLAN EXCLUSIONS" section.

- **Rehabilitative therapy services—Outpatient services:**
  - Rehabilitative therapies provided in an Outpatient or home setting (when the patient is homebound) that are directed at improving physical functioning and are expected to result in significant improvement within two months of commencement.

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  - Such therapies include but are not limited to speech, physical, occupational, cardiac (excluding Phase III) and pulmonary therapy services.
  - Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section.
  - See also "Cardiac rehabilitation services", "Custodial Care or convalescent care", "Institutional care" and "Speech therapy" in the "PLAN EXCLUSIONS" section.

- **Sexual abuse or sexual assault victims:**
  - Hospital and medical services in connection with sexual abuse or sexual assaults that are of an emergency nature.
  - The Deductible, Copayment and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section will be waived (this does not apply to a Covered Person who has elected and is participating in the qualified High Deductible Health Plan (HDHP) option).

- **Sleep diagnostics, evaluations and supplies:** Sleep studies/tests, labs and medical equipment for sleep disorders when ordered by a Physician.
  - Medications prescribed for sleep aid are addressed in the "PRESCRIPTION DRUG BENEFITS" section.

- **Sterilization procedures:**
  - Elective sterilization procedures, such as a tubal ligation.
  - Vasectomies performed as an office procedure.
  - Female sterilization procedures intended for Contraceptive purposes only are included under the preventive care services benefit.
  - Female sterilization procedures that are medical in nature and for non-Contraceptive purposes are subject to the appropriate Deductible and/or Copayment or Coinsurance listed in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - See also "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Reversal of sterilization" in the "PLAN EXCLUSIONS" section.

- **Telehealth services:**
  - Telehealth services, to the same extent as benefits provided for other services.
  - Telehealth services include medical exams and consultations, psychiatric and behavioral health (including Substance Use Disorder evaluations and treatment), and licensed dietitians, nutritionists and certified diabetes educators who counsel senior diabetes patients in their homes to remove the hurdle of transportation for them to receive treatment.
  - For purposes of this subsection, "telehealth" means the delivery of clinical services via synchronous, interactive audio and video communications systems that permit real-time communication between the Provider and the patient. Services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology. Telehealth provides remote access for face-to-face services such as consultations, office visits, preventive care, and mental health services. Telehealth, through technology, replicates the interaction of a traditional in-person encounter between a Provider and a patient.
  - The telehealth services benefit does not include virtual visits. Virtual visits is a separate benefit. See also "Virtual visits" in this "MEDICAL BENEFITS—BENEFITS" section.

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- **Temporomandibular joint (TMJ) disorder treatment:** Treatment of TMJ and other jaw joint disorders.
  - Benefits are subject to the limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section."
  - See also "Mandibular and maxillary osteotomy" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Tobacco cessation programs:**
  - Expenses incurred for tobacco cessation programs, subject to the benefit limitations specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, MAXIMUM BENEFITS" section, when such programs are provided through the Quit for Life® tobacco cessation program.
  - Individuals enrolled in the Quit for Life® tobacco cessation program are eligible for 12 weeks of benefits for any one of the following: Zyban® (buproprion), Chantix™ or other over-the-counter Nicotine Replacement Therapy (NRT). NRT must be obtained via prescription for the Copayment to apply. If NRT is purchased through the Quit for Life® mail-order program, no Copayment will apply.
  - The Copayment amount specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, TYPE OF PRESCRIPTION DRUG EXPENSE" section applies for tobacco cessation products (except NRT obtained through the Quit for Life® mail-order program).
  - Tobacco cessation pharmacological therapy, as specified on the Prescription Drug Formulary, is included under the "PRESCRIPTION DRUG BENEFITS" section.
  - See also "Preventive care services" in this "MEDICAL BENEFITS—BENEFITS" section.
  - For more information about this benefit, contact the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION", or customer service at the phone number on the Plan ID Card.

- **Urgent Care:**
  - Services obtained in a Physician's office or at an urgent care center.
  - Urgent Care services are intended for immediate Outpatient treatment for an unforeseen Illness, Injury or condition to prevent serious deterioration.
  - Urgent care centers also may be referred to as convenient care, prompt care or express care centers and treat patients on a walk-in basis without a scheduled appointment.
  - Urgent Care received outside of the United States of America provided the Covered Person did not travel to such location for the sole purpose of receiving medical services, drugs or supplies.
  - See also "Emergency Services" in this "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Foreign travel" in the "PLAN EXCLUSIONS" section.

- **Virtual visits:**
  - Virtual visits through MDLive. The virtual visits benefit provides Covered Persons with access to quality health care services from their home, office or anywhere there is Internet connectivity.
  - For purposes of this subsection, "virtual visit" means Provider services, such as medical exams and consultations, delivered by use of a web-based portal or other electronic media. A virtual visit is intended to be used as an alternative to an in-person office visit.
  - Covered Persons can speak to a board-certified doctor or counselor anytime, day or night (including weekends and holidays) by phone or secure video through MDLive.com or the MDLIVE app, and can be seen for more than 50 common conditions, including acne, allergies, behavioral health, cold/flu, cough, ear problems, fever, headache, insect bites, nausea/vomiting, pink eye, rash, and respiratory problems.

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

  - Visit the virtual visits website at MDLIVE.com/hacare or call (888) 912-0904.
  - The virtual visits benefit does not include telehealth services. Telehealth services is a separate benefit. See also "Telehealth services" in this "MEDICAL BENEFITS—BENEFITS" section.

- **Vision care:**
  - Vision screenings and examinations for prescribing glasses, or for determining the refractive state of the eyes.
  - One pair of eyeglasses or one contact lens per affected eye following cataract surgery. The maximum allowable benefit for frames and lenses is the standard allowable established by the Centers for Medicare and Medicaid Services (CMS). The allowable amount may be applied to the purchase of deluxe frames.
  - See also "Vision care" in the "PLAN EXCLUSIONS" section.

**SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES**

This subsection applies for Plan Years beginning on or after January 1, 2022. Group health plans are required to address patient protections related to Surprise Medical Billing. These protections are described below.

**Definitions for Purposes of Surprise Medical Billing Protections.** Note: See also the "DEFINED TERMS" section for definitions of other capitalized terms included in the definitions that follow.

- "Certified Independent Dispute Resolution Entity (CIDRE)" means an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

- "Emergency Services" means an appropriate medical screening examination (as required under Section 1867 of the Social Security Act, Emergency Medical Treatment and Labor Act (EMTALA)) that is within the capability of a Hospital emergency department or of an Independent Freestanding Emergency Department. This includes ancillary services routinely available to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital or Independent Freestanding Emergency Department and required under EMTALA to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

  When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include items or services provided by a Non-Preferred Provider or non-Participating Health Care Facility (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is stabilized and as part of Outpatient observation or an inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Covered Person is able to travel using non-medical transportation or non-emergency medical transportation, and the Covered Person is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Preferred Provider.

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

- "Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides Emergency Services.

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- "Maximum Allowable Charge" means the term as defined in the "DEFINED TERMS" section, and further means, for a benefit claim that is determined to meet requirements to be considered under the Surprise Medical Billing Protections process: if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified Independent Dispute Resolution Entity (CIDRE) or a court of competent jurisdiction, if applicable.

- "Participating Health Care Facility" means a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by applicable law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a health care item or service. A single direct contract or case agreement between a health care facility and a group health plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

- "Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans administered by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), as the total maximum payment (includes the cost-sharing amount imposed for such item or service and the amount paid by the Plan) for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, the amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

- "Recognized Amount" means, except for Non-Preferred Provider air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Preferred Provider air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

- "Surprise Medical Billing" means an unexpected balance bill for certain types of services, supplies or treatment provided by a Non-Preferred Provider for which the Plan did not provide a benefit. Examples of Surprise Medical Billing include:
  - Unexpected balance bills:
    - For emergency services, supplies or treatment received at a Non-Preferred Provider or facility;
    - For certain Non-Preferred Provider non-emergency services, supplies or treatment provided by a Participating Health Care Facility, provided the Covered Person has not validly waived their rights relating to Surprise Medical Billing Protections, and
    - For Non-Preferred Provider air ambulance services.

- "Surprise Medical Billing Protections" means, when applicable to this Plan, law(s) that provide protections against certain health care provider and/or facility billing practices that result in a patient receiving unexpected bills for certain health care services in certain situations.

- "Usual, Customary and Reasonable Charge" means the term as defined in the "DEFINED TERMS" section, and further means, for a benefit claim that is determined to meet requirements to be considered under the Surprise Medical Billing Protections process: if no negotiated rate exists, the Usual, Customary and Reasonable Charge will be an amount deemed payable by a Certified Independent Dispute Resolution Entity (CIDRE) or a court of competent jurisdiction, if applicable.

## MEDICAL BENEFITS

**IMPORTANT! PLEASE NOTE:**

- Certain services require notification or Preauthorization. See "SERVICES REQUIRING PREAUTHORIZATION" in the "PREAUTHORIZATION" section for details.
- Most, but not all, of the Plan benefits available are subject to the Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Benefit levels and limitations can be found in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

**How Surprise Medical Billing Protections Work.** For Non-Preferred Provider benefit claims subject to Surprise Medical Billing Protections, cost-sharing will be the same amount as would be applied if the services, supplies and/or treatment were provided by a Preferred Provider and will be calculated as if the Plan's allowable expense is the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. Surprise Medical Billing Protections prohibit Providers from pursuing Covered Persons for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan cost-sharing as described in the "SCHEDULE OF BENEFITS" section. Any such cost-sharing amounts will accrue toward the Preferred Provider Deductibles and Out of Pocket Maximums.

If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is a Preferred Provider and the Covered Person receives such item or service in reliance on that information, the Covered Person's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum will be calculated as if the Provider had been a Preferred Provider despite that information proving inaccurate.

**Claims:** Benefit claims subject to the Surprise Medical Billing Protections will be denied or paid by the Plan within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider. See the "HOW TO SUBMIT A CLAIM AND CLAIMS DENIAL APPEAL PROCEDURE—Claims Review Procedure" section.

**External Review of an Adverse Benefit Determination.** The external review process described in the "HOW TO SUBMIT A CLAIM AND CLAIMS DENIAL APPEAL PROCEDURE— Claims Denial Appeal Procedure, Notice of Appeal Determination" section also applies to an Adverse Benefit Determination that involves consideration of whether the Plan is complying with the Surprise Medical Billing Protections and cost-sharing based on applicable law.

## PLAN EXCLUSIONS

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

Expenses incurred for the following items, services, supplies and treatment are specifically excluded and no benefits are payable under the Plan except as otherwise provided herein:

- **Abortion:** Expenses incurred for and in connection with an abortion unless the life or physical health of the Covered Person who is Pregnant is in imminent danger.

- **Alternative medicine:** Expenses incurred for treatment and services related to acupuncture, acupressure and hypnotherapy.

- **Bariatric surgery-related services:** Reconstructive surgery to remove excess skin primarily for cosmetic reasons rather than for Medical Necessity.
  - See also "Bariatric surgery" in the "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Cosmetic surgery" and "Obesity treatment and products" in this "PLAN EXCLUSIONS" section.

- **Blood processing:** Costs related to the processing and storage of blood and its components from a person designated as a donor.
  - See also "Blood" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Cardiac rehabilitation services:** Cardiac rehabilitation Phase III.
  - See also "Rehabilitative therapy services—Outpatient services" in the "MEDICAL BENEFITS—BENEFITS" section.

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

- **Clinical trials:** Non-routine costs, such as treatments, procedures, drugs, devices, services, or items that are the subject of the Approved Clinical Trial or any other investigational treatments.
  - For purposes of this subsection, "Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is approved or funded by a federally funded trial or a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - See also "Clinical trials" in the "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Experimental treatments/procedures/drugs/devices/transplants" in this "PLAN EXCLUSIONS" section.

- **Convenience or comfort items:** Convenience or comfort items, including but are not limited to grab bars, tub transfers, seat lifts, raised toilet seats, phones and televisions.

- **Cosmetic surgery:** Surgery for cosmetic purposes and not primarily for reasons of Medical Necessity, including but not limited to rhinoplasties, breast reductions, blepharoplasties, liposuction and removal of skin tags and lipomas when not done primarily because of Medical Necessity.
  - See also "Bariatric surgery-related services" and "Skin lesions" in this "PLAN EXCLUSIONS" section.
  - See also "Reconstructive surgery" in the "MEDICAL BENEFITS—BENEFITS" section.

## PLAN EXCLUSIONS

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

- **Counseling:** Marital or social counseling unrelated to mental health conditions.
  - See also "Mental Health Disorder/Substance Use Disorder services and treatment" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Custodial or convalescent care:** Custodial Care or convalescent care, including but not limited to such care received in an acute general Hospital, Skilled Nursing Facility or home.
  - See also "Institutional care" in this "PLAN EXCLUSIONS" section.
  - See also "Rehabilitation and Skilled Nursing Care—inpatient services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Dental services:**
  - Dental services, except where specifically stated in the "MEDICAL BENEFITS—BENEFITS" section.
  - Services related to Injuries caused by or arising out of the act of chewing.
  - Hospitalizations for dental work unless the hospitalization is necessary due to a medical condition.
  - See also "Dental services" and "Oral surgery" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Disposable items:** Self-administered dressings and other disposable supplies.
  - See also "Durable Medical Equipment and orthopedic appliances" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Durable Medical Equipment, orthopedic appliances and devices:**
  - The following corrective and orthopedic appliances and devices unless otherwise stated herein: hearing aids, earmolds, shoes, heel cups, arch supports, gloves, lifts and wedges.
  - Wheelchairs (manual or electric) and lift chairs unless the Covered Person would be bed- or chair-confined without such equipment.
  - Any dispensing fees incurred in obtaining these items.
  - See also "Hair loss care and treatment" and "Hearing devices and related services" in this "PLAN EXCLUSIONS" section.
  - See also "Durable Medical Equipment and orthopedic appliances", "Orthotics", "Prostheses" and "Reconstructive surgery" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Experimental treatments/procedures/drugs/devices/transplants:**
  - Unless otherwise stated herein, the Plan does not provide benefits for expenses incurred for or related to any medical treatment, procedure, drug, device or transplant that is determined by a Medical Director to meet one or more of the following standards or conditions:
    - The medical treatment, procedure, drug, device or transplant is otherwise under study to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for a condition, disease or Illness.
    - The consensus of opinion among experts regarding the medical treatment, procedure, drug, device or transplant is that further studies are necessary to determine its safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis for a condition, disease or Illness.
    - The drug or device cannot be lawfully marketed for a condition, disease or Illness without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is prescribed or furnished.
    - The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a condition, disease or Illness does not conform with standards of good medical practice and is not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

    - ➢ The medical treatment, procedure, drug, device or transplant for the treatment or diagnosis of a condition, disease or Illness is determined by a Medical Director to be experimental or investigational.
  - See also "Clinical trials" in this "PLAN EXCLUSIONS" section.
  - See also "Clinical trials" and "Human organ transplant services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Fitness:** Any program designed for overall physical fitness or membership to fitness facilities for the same purpose. This exclusion does not apply to rehabilitative therapy.

- **Foot care:**
  - Care for weak, unstable or flat feet, or bunions, unless an open cutting operation is performed, or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed.
  - The purchase of orthopedic shoes, shoe inserts, wedges, heel cups or other devices for support of the feet, except for Medically Necessary custom-molded foot orthotics.
  - See also "Durable Medical Equipment, orthopedic appliances and devices" in this "PLAN EXCLUSIONS" section.

- **Foreign travel:** Expenses incurred outside of the United States of America if the Covered Person traveled to such locations to obtain medical services, drugs or supplies, or such services, drugs or supplies are unavailable or illegal in the United States of America.
  - See also "Emergency Services" and "Urgent Care" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Genetic testing:**
  - Genetic testing for individuals from the general population at average risk, except to the extent that benefits for genetic testing are required to be provided pursuant to applicable law.
  - Selected high-risk patients who meet medical criteria may qualify for screening for certain diagnoses (e.g., breast cancer, cystic fibrosis, hemoglobin disorders). Such screening is subject to the applicable Deductibles, Copayments and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section, except as otherwise provided herein.
  - For purposes of this subsection, "genetic testing" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, if the analysis detects genotypes, mutations or chromosomal changes. Genetic testing does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition.
  - See also "Preventive care services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Governmental responsibility:** Care for disabilities connected to military service for which the Covered Person is legally entitled to services and for which facilities are reasonably available, or for conditions that state or local laws require be treated in a public facility, unless legal liability exists.

- **Hair loss care and treatment:** Care and treatment for hair loss, including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

- **Hearing devices and related services:**
  - Hearing aids and their fittings or testing for the purpose of using a hearing aid.
  - Any service, supply or treatment for the rehabilitation of hearing impairment, except as may be otherwise included under the preventive care services benefit.
    - ➢ See also "Preventive care services" in the "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Hearing evaluations" in the "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Durable Medical Equipment, orthopedic appliances and devices" in this "PLAN EXCLUSIONS"

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

section.

- **Human organ donor services and treatment:** Organ donor services and treatment when a Covered Person serves as the organ donor for a non-covered recipient. This includes expenses incurred related to the procurement of an organ or tissue.
  - See also "Human organ transplant services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Human organ transplants:** For Covered Persons who have primary coverage under Medicare Parts A and B, human organ and tissue transplants for which Medicare denies transplant benefits.
  - See also "Human organ transplant services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Illegal activities:** Expenses incurred for any service, supply or treatment that arose out of or occurred while engaged in any illegal or criminal enterprise or activity.
  - This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- **Impotence:** All forms of treatment (medical or surgical) for impotence.

- **Infertility services:** See the "ADDENDUM: ENHANCED INFERTILITY SERVICES" section for details.
  - See also "Infertility services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Institutional care:** Institutional care for the primary purpose of controlling or changing a Covered Person's environment, or is maintenance care, Custodial Care, domiciliary care, convalescent care or a rest cure.
  - See also "Custodial Care or convalescent care" in this "PLAN EXCLUSIONS" section.
  - See also "Rehabilitation and Skilled Nursing Care—inpatient services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Medicare benefits:** If a Covered Person is eligible for Medicare as their primary coverage, but not enrolled in Medicare, Plan benefits are reduced by the amount Medicare would have paid, without regard to whether such benefits are actually received from Medicare.

- **Obesity treatment and products:**
  - Special formulas, food supplements, special diets, minerals, vitamins or Physician and non-Physician supervised weight loss programs.
  - Surgical intervention (unless otherwise stated herein), treatment and products for obesity, food addiction or weight reduction.
  - See also "Bariatric surgery" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Outpatient retail Prescription Drugs:** Outpatient retail Prescription Drugs are not included under the "MEDICAL BENEFITS—BENEFITS" section.
  - See also the "PRESCRIPTION DRUG BENEFITS" section.
  - See also the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - See also "Outpatient Specialty Prescription Drugs provided through the medical benefit" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Private duty nursing:** Expenses incurred in connection with care, treatment or services of a private duty nurse.

- **Reversal of sterilization:** A surgical procedure to reverse voluntary sterilization and any resulting Infertility services.
  - See also "Sterilization procedures" in the "MEDICAL BENEFITS—BENEFITS" section.

## PLAN EXCLUSIONS

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

- **Self-inflicted Injury or Illness:** A loss due to an intentionally self-inflicted Injury or Illness.
  - This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- **Services that are not Medically Necessary:**
  - Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage.
  - Vocational rehabilitation services, or other services or supplies that are not Medically Necessary for the treatment, maintenance or improvement of a Covered Person's health.
  - Services that are not primarily medical in nature including but not limited to traditional mattresses, air filters, Jacuzzis/spas, swimming pools, exercise equipment, gym memberships, air conditioners, adaptive devices/filters for residential heating and air conditioning systems, car seats and educational services.

- **Skin lesions** Skin lesion removal primarily for cosmetic reasons rather than for Medical Necessity.
  - See also "Cosmetic surgery" in this "PLAN EXCLUSIONS" section.

- **Speech therapy:**
  - Any service, supply or treatment for speech therapy connected with a learning disability, developmental disorder or functional nervous disorder.
  - Therapy for conditions when improvement is not anticipated within two months of commencement.
  - See also "Rehabilitation and Skilled Nursing Care—inpatient Services" and "Rehabilitative therapy services—Outpatient services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Supplemental drinks/vitamins/weight gain products:** Over-the-counter supplies or products taken to supplement caloric intake, not primarily medical in nature and not used as the sole source of nutrition.

- **Travel or accommodations:** Expenses incurred for travel or accommodations, whether or not recommended by a Physician, are not considered Eligible Expenses, except where specifically stated in the "MEDICAL BENEFITS—BENEFITS" section.
  - See also "Ambulance services" and "Human organ transplant services" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Vision care:**
  - Vision exams and screenings, unless otherwise stated herein.
  - Eyeglasses, contact lenses, contact lens evaluations and fittings, unless there is a diagnosis of cataract or unless otherwise stated herein.
  - Lens tinting, scratch-protection coating, progressive lenses (no-line bifocals or trifocals), anti-reflective coating and oversized lenses.
  - Refractive eye surgery, including but not limited to, refractive keratectomy, radial keratotomy and laser-assisted *in-situ* keratomileusis (LASIK) surgery.
  - See also "Vision care" in the "MEDICAL BENEFITS—BENEFITS" section.

- **Other excluded expenses:**
  - Surveillance testing, except as otherwise specifically provided herein.
  - Any service, supply or treatment that is not prescribed by a Physician or a qualified Provider.
  - Any service, supply, treatment, diagnosis or advice for which the Covered Person is not legally required to pay.

## PLAN EXCLUSIONS

**IMPORTANT! PLEASE NOTE:**

- All exclusions related to dental benefits and Prescription Drug benefits can be found in the "DENTAL BENEFITS" section and "PRESCRIPTION DRUG BENEFITS" section.

- Any service, supply or treatment prohibited by the laws of the United States of America or the state where the expense was incurred.
- Any care, treatment, service or supply furnished by a facility owned or operated by a state or national government, unless the Covered Person is legally obligated to pay for the care or treatment or if the United States of America has the authority to recover or collect the reasonable cost of such care or service.
- Any Injury or Illness arising out of, or occurring in the course of, the Covered Person's job for wage or profit which is covered by Workers' Compensation or similar law.
- Expenses incurred for appointments scheduled and not kept (missed appointments) or for the preparation of medical abstracts or completion of claim forms.
- Expenses incurred before the Covered Person's coverage goes into effect or after termination from the Plan.
- Services provided by a non-licensed professional.
- Care ordered or directed by individuals other than a Physician, registered clinical psychologist or other qualified Provider.
- Court-ordered evaluations or treatment, care in lieu of detention or correctional placement or family retreats.
- Services furnished or billed by a Provider that have been excluded or debarred by the federal government.
- Services and supplies not specifically mentioned in the Plan.

# PRESCRIPTION DRUG BENEFITS

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

Outpatient Pharmacy benefits are administered through a national pharmacy benefit manager. Many independent Pharmacies and most national chains are considered Preferred Pharmacies. To find out if a Pharmacy is a Preferred Pharmacy, call the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section or on the Plan ID Card.

Benefits for Prescription Drugs and supplies are available when prescribed by a Physician in connection with Medically Necessary services. Retail Prescription Drugs and Specialty Prescription Drugs may be prescribed by a Non-Preferred Provider but must be dispensed by a Preferred Pharmacy (for retail Prescription Drugs) or the Carle Specialty Pharmacy (for Specialty Prescription Drugs).

The Covered Person must present their Plan ID Card for each prescription purchase. The Plan ID Card contains information required to process prescriptions for payment to the Pharmacy. The applicable Copayment and/or Coinsurance is required to be paid when the prescription is filled. If the Plan ID Card is not presented, the full retail price of the prescription may be required to be paid.

- To request reimbursement for payment made at a Pharmacy, submit the itemized receipt, along with the requested information noted on it, to the pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section or on the Plan ID Card.

## PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION

Drugs that require Preauthorization are noted on the Prescription Drug Formulary. Newly released Prescription Drugs may require Preauthorization for up to 12 months from the date of launch.

To obtain Preauthorization, the Provider on the Covered Person behalf, or the Covered Person, must contact the pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section.. Failure to obtain Preauthorization may result in denial of benefits for the Prescription Drug.

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

## PRESCRIPTION DRUG FORMULARY

To access the most up-to-date Formulary information, visit the Third Party Administrator's website whose contact information can be found in the "GENERAL PLAN INFORMATION" section, or call customer service at the phone number on the Plan ID Card.

Covered Persons can use the Formulary to determine if a drug requires Preauthorization, step therapy, or has a quantity limit. The Formulary specifies the tier placement for each drug. These tiers will help Covered Persons estimate how much they will pay each time they fill a prescription.

Prescription Drugs may be moved to a higher or lower cost sharing tier, or removed from the Formulary. If a drug moves to a higher tier level, or is removed from the Formulary, the Covered Person will be notified at least 60 days prior to the change so that they can discuss with their Physician any lower tier level or Formulary alternatives that are available.

Some Prescription Drugs are not included on the Formulary. Non-formulary drugs have Formulary alternatives in most instances. If available, benefits for non-formulary drugs require a request for medical exception from the Covered Person's Physician or Provider or authorized representative. The medical exception request must include the reason Formulary alternatives cannot be used. Medical exceptions may be requested by using the Preauthorization Request Form which can be found on the Third Party Administrator's website whose site address can be found in the "GENERAL PLAN INFORMATION" section.

# PRESCRIPTION DRUG BENEFITS

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

## ELIGIBLE PRESCRIPTION DRUG EXPENSES

This subsection describes the services, supplies and treatment for which benefits are available when they are determined to be Eligible Expenses.

- Drugs prescribed by a Physician that require a prescription either by federal or state law, but excluding any drugs specified as excluded expenses under the Plan.
- **Compounded prescriptions.** Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- **Contraceptives:**
  - U.S. Food and Drug Administration (FDA)-approved female Contraceptive products/methods, when prescribed by a Physician.
    - This includes Contraceptive pills, patches, ring, injections and over-the-counter (OTC) products/ methods (male condoms are excluded from this benefit).
    - Prescription Contraceptives or their substitutable generic equivalent when prescribed for the purpose of preventing conception, and which are approved by the FDA.
  - Generic Contraceptives are available at no cost sharing to the Covered Person when obtained at a Preferred Pharmacy.
  - If a generic version of a Prescription Drug Contraceptive 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.
- **Treatment of a dental condition:** Prescription Drugs for the treatment of a dental condition.
- **Diabetic supplies:**
  - Glucagon emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors.
  - Diabetic supplies must be obtained with a prescription from a Physician.
- **Infertility treatment:** Specialty Prescription Drugs prescribed for Infertility treatment are included under the "Specialty Prescription Drugs" subsection.
- **Immunosuppressive therapy drugs:**
  - Prescription immunosuppressive therapy Drugs, brand or otherwise, to prevent the rejection of transplanted organs and tissues, and includes "may not substitute" on the prescription.
  - The Plan does not require, or cause a pharmacist to interchange another immunosuppressant drug or formulation, without notification and the documented consent of the prescribing Provider and Covered Person, or the Covered Person's legal representative if they are unable to provide consent. This does not apply to immunosuppressant drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.
- **Injectable syringes:** Injectable syringes, when the injectable drug is determined to be an Eligible Expense.

## PRESCRIPTION DRUG BENEFITS

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

- **Over-the-counter (OTC) medications:**
  - A limited number of OTC medications.
  - A prescription is required from a Physician for these OTC products.
  - For a list of eligible OTC products, contact the pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section.
  - See also "Preventive drug therapy" in this "ELIGIBLE PRESCRIPTION DRUG EXPENSES" subsection.

- **Physician-prescribed prenatal prescription vitamins.**

- **Preventive therapy drugs:**
  - Preventive therapy drugs are listed on the Formulary.
  - Preventive therapy drugs, including evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Service Task Force (USPSTF) and that the USPSTF may upgrade to Grade A or B during a Benefit Period, are provided at no cost sharing to the Covered Person when obtained at a Preferred Pharmacy. For a list of current USPSTF recommendations, visit the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

- **Reversal agent or antidote for opioid overdose:** Physician-prescribed generic naloxone intramuscular injections only.

- **Sleep disorder treatment:** Medications prescribed for sleep aid.

- **Specialty Prescription Drugs (including specialty Infertility drugs):**
  - Specialty Prescription Drugs, as specified on the Formulary, must be obtained from the Plan's specialty Pharmacy vendor, Carle Specialty Pharmacy.
  - Benefits, if available, are subject to a prior written order by the Covered Person's Physician.
  - The Tier 4, Tier 5 and/or Tier 6 Copayments or Coinsurance apply as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section. Tier 4 Specialty Prescription Drugs are the most clinically and cost effective. These are known as Preferred Specialty Drugs. Tier 5 Specialty Prescription Drugs have a higher cost than the Tier 4 Specialty Prescription Drugs and usually have clinically comparable alternatives available at the Tier 4 benefit level. These are known as Non-Preferred Specialty Drugs. Tier 6 Specialty Prescription Drugs have the highest cost and are drugs that may not have the clinical advantages of Tier 4 or Tier 5 Specialty Drugs. The three-tier system helps manage costs, but provides flexibility and benefits for Covered Persons who choose a higher-tiered drug.
  - Newly available Specialty Prescription Drugs must go through a review process to determine if they will be added to the Formulary.
  - 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.
  - See also "Outpatient Specialty Prescription Drugs provided under the medical benefit" in the "MEDICAL BENEFITS—BENEFITS" section for other specialty drug-related items.

- **Tobacco cessation pharmacological therapy:**
  - Zyban® (bupropion), Chantix™ and over-the-counter Nicotine Replacement Therapy (NRT), when the Covered Person is enrolled in the Quit for Life® tobacco cessation program.
  - Benefits are limited to a 12-week supply.

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

  - The Copayment amount specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section applies.
  - NRT must be obtained via prescription for the Copayment to apply. No Copayment will apply to NRT purchased through the Quit for Life® tobacco cessation program's mail-order program.
  - See also "Tobacco cessation programs" in the "MEDICAL BENEFITS—BENEFITS" section.

**COPAYMENTS, COINSURANCE AND DISPENSING LIMITATIONS**

This subsection describes the Copayment, Coinsurance and dispensing limitations that apply.

- The following applies to Covered Persons participating in the qualified high deductible health Plan (HDHP) option that is paired with a health savings account (HSA):
  - Prescription Drug and Specialty Prescription Drug benefits are subject to the applicable Deductibles specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
  - Covered Persons enrolled in the HDHP are required to pay 100 percent of their Prescription Drug and Specialty Prescription Drug expenses until the applicable Deductible has been satisfied.

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

- A Covered Person's Deductible, Copayment and Coinsurance amounts for a 30-day supply of prescription insulin drugs will not exceed the amount specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

- A Covered Person pays the lesser of the Pharmacy's regular charge for the drug or the Deductible, Copayment and Coinsurance specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section for each initial prescription or prescription refill.

- Most, but not all, generic drugs will be dispensed under the Tier1 Copayment when they exist and are available and allowable by applicable state or federal law.

- If a brand-name drug is requested by the Covered Person or their Physician when a generic form of the drug exists, the Covered Person will pay the Tier 3 (Non-Preferred brand-name drug) Copayment plus the difference in cost between the generic drug and brand-name drug.

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

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

- If a higher tiered drug is determined to be Medically Necessary by the Covered Person's Physician, the Covered Person may qualify to pay a reduced tier Copayment. The Covered Person must contact the pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section to determine if they qualify for a reduced tier Copayment.

- Certain brand-name drugs will be dispensed at the Tier 2 or Tier 3 Copayment, even when a generic equivalent is available, when requested by a Physician. In this instance, only the Tier 2 or Tier 3 Copayment applies. These

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

drugs include, but are not limited to, Tegretol®, Lanoxin®, Dilantin®, Coumadin® and Ritalin®, and are subject to change.

- A 90-day supply of maintenance medications may be obtained at certain Preferred retail Pharmacies. For a list of these Pharmacies, contact the pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

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

## PHARMACY SAVINGS PROGRAM

**Retail 90 Program.** The Retail 90 program allows Covered Persons to purchase 90-day supplies of certain maintenance medications used to treat common conditions such as asthma, high cholesterol, high blood pressure and diabetes. Depending on the Plan's Prescription Drug benefit structure, a 90-day supply may be obtained at a discounted cost. The Health Alliance Pharmacy and Therapeutics Committee determines the medications eligible for this value-based benefit based on the value they have for keeping an individual healthy. Because this is a voluntary program designed to increase flexibility, Covered Persons who prefer may continue purchasing the traditional 30-day supply from their Pharmacy subject to the regular Copayment as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.

A listing of the medications included in the Retail 90 program is available on the pharmacy benefit manager's website (or by calling the pharmacy benefit manager at the phone number) listed in the "GENERAL PLAN INFORMATION" section.

## PRESCRIPTION DRUG EXCLUSIONS

Expenses incurred for the following items, services, supplies and treatment are specifically excluded and no benefits are payable under the Plan except as otherwise stated herein:

- Prescription Drugs not obtained from a Preferred Pharmacy, unless obtained for an Emergency Medical Condition.

- Prescription Drugs for the treatment of erectile dysfunction.

- Non-prescription drugs or medications, except for diabetic supplies that are determined to be Eligible Expenses and tobacco cessation products when the Covered Person is enrolled in the tobacco cessation program offered by the Plan.

- Products classified as medical food or supplements.

- Prescription strengths written for OTC medications.

- When a medication is available both by prescription (federal legend) and as an OTC product, the Prescription Drug is considered an exclusion unless otherwise stated herein.

- Prescription Drugs not considered Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by the pharmacy benefit manager, including but not limited to BOTOX®, psoralens, tretinoin and oral antifungal agents for cosmetic use, tobacco cessation products that are not approved

**IMPORTANT! PLEASE NOTE!**

- Certain Prescription Drugs require Preauthorization. For details, see "PRESCRIPTION DRUGS REQUIRING PREAUTHORIZATION" in this "PRESCRIPTION DRUG BENEFITS" section and the "PREAUTHORIZATION—SERVICES REQUIRING PREAUTHORIZATION" section.
- Unless otherwise stated herein, Prescription Drug benefits are subject to the Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

for use with the tobacco cessation program offered by the Plan, anorexiants or weight loss medications, anabolic steroids, oral fluoride preparations, and hair removal or hair growth promoting medications.

- Devices of any type, even if such devices may require a prescription, including but not limited to therapeutic devices, artificial appliances, support garments, bandages, etc. Prescription Contraceptive devices are not included in this exclusion.

- Any drug labeled, "Caution – Limited by Federal Law to Investigational Use," or experimental or other drugs prescribed for unapproved uses.
  - Prescription Drugs for cancer treatment are considered Eligible Expenses if the drug is approved by the U.S. Food and Drug Administration (FDA) and is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) the National Comprehensive Cancer Network's Drugs & Biologicals Compendium; (3) the Thomson Micromedex's Drug Dex; (4) the Elsevier Gold Standard's Clinical Pharmacology; or (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services; or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer-reviewed professional medical journals published in the United States of America or Great Britain.

- Prescription Drugs for which the cost is recoverable under any Workers' Compensation or Occupational Disease law or from any state or governmental agency, or any medication furnished by any other drug or medical service for which there is no charge.

- Any expense incurred for the administration of a drug.

- Replacement of lost, destroyed or stolen medication and any supplies for convenience.

- Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.

- Any drug determined to be abused or otherwise misused by a Covered Person.

- Prescription Drugs received outside of the United States of America, unless received as part of Emergency Services or Urgent Care.

- Drugs which have not been approved as effective by the Food and Drug Administration (FDA), including DESI drugs.

**DRUG LIMITATIONS**

Certain Prescription Drugs may be subject to drug limitations based on FDA-approved dosage recommendations and the drug manufacturer's package size. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies.

# DENTAL BENEFITS

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

The dental benefits of the Plan apply when eligible dental expenses are incurred by a person while enrolled in the 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, to verify Plan benefits before the expense is incurred.

## ELIGIBILITY APPLICABILITY FOR DENTAL BENEFITS

An Employee, their Spouse or Domestic Partner, and/or their Dependent children, may enroll in the Plan for dental benefits only. An Employee's Spouse or Domestic Partner and Dependent children are not eligible for dental benefits unless the Employee has enrolled for dental benefits.

Retired Employees and their Dependents are not eligible for dental benefits.

## DEDUCTIBLE

**Deductible Amount.** The Deductible amount is a specified dollar amount that a Covered Person must pay towards expenses incurred, if determined to be Eligible Expenses, before any benefits will be paid by the Plan during the Benefit Period. The Deductible amount can be found in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section. A new Deductible will apply each Benefit Period.

**Family Unit Limit.** When the dollar amount shown in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section has been incurred by members of a Family Unit toward their Benefit Period Deductible, the Deductibles of all members of that Family Unit will be considered satisfied for that period.

## BENEFIT PAYMENT

Each Benefit Period, the Plan will provide benefits for Eligible dental Expenses incurred by a Covered Person in excess of the Deductible amount, if applicable. Benefits, if determined to be Eligible Expenses, for expenses incurred will be considered at the benefit levels shown in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section. No benefits will be provided in excess of the Usual, Customary and Reasonable Charges.

## MAXIMUM BENEFIT AMOUNTS

The Maximum Benefit amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section are the maximum amount of benefits for the specified services that the Plan will provide for benefits, if available, for expenses incurred by a Covered Person. No benefits will be provided in excess of those amounts.

## EXPENSES INCURRED FOR ELIGIBLE DENTAL SERVICES

Expenses incurred for eligible dental services are the Usual, Customary and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed in the "ELIGIBLE DENTAL EXPENSES" subsection. If the charge exceeds the Usual, Customary and Reasonable Charge, the Covered Person will be responsible for the difference in cost, plus any Coinsurance or Deductible amount.

If determined to be an Eligible Expense:

- a crown, bridge or cast restoration is considered incurred on the date the tooth is prepared.
- any other prosthetic device is considered incurred on the date the master impression is made.
- root canal treatment is considered incurred on the date the pulp chamber is opened.
- orthodontic treatment is incurred on the date the Active Appliance is first placed.
- all other Eligible Expenses incurred are considered incurred on the date the services are furnished.

## DENTAL BENEFITS

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

### PREDETERMINATION OF BENEFITS

If the Covered Person's Dentist recommends a course of treatment for which the expense is expected to be more than the amount shown in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section, the Plan recommends that their Dentist prepare and submit to the Third Party Administrator, on behalf of the Plan, a Treatment Plan describing the planned treatment, copies of necessary X-rays, photographs and models, and an estimate of the charges for such, prior to beginning the course of treatment. The Third Party Administrator will review the Treatment Plan and return it to the Dentist explaining the portion for which the Plan has authorized benefits. The Dentist will then review this with the Covered Person before treatment begins. **A Treatment Plan is not required for Emergency Services.**

### ELIGIBLE DENTAL EXPENSES

This subsection describes the services, supplies and treatment for which benefits are available when they are determined to be Eligible Expenses. The Plan Administrator or its designee determines what is considered the Usual, Customary and Reasonable Charge. Covered Persons are responsible for any portion of the bill that exceeds the Usual, Customary and Reasonable Charge.

Contact the Third Party Administrator whose phone number can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number listed on the Plan ID Card, concerning any dental service that is not specifically listed in the Plan.

- **Preventive and Diagnostic Dental Services.** The following services and treatments:
  - Dental sealants; Limited to Dependent children age 17 and younger.
  - Diagnostic services – X-rays, including the following:
    - Full mouth series or at least 14 films, including bitewings, if necessary; Limited to once in any consecutive 36-month period;
    - Bitewing films; Limited to a maximum of four films in any consecutive six-month period;
    - Other intraoral periapical or occlusal films (single films);
    - Extraoral superior or inferior maxillary film; and
    - Panoramic film, maxilla and mandible; Limited to once in any consecutive 36-month period.
  - Diagnostic services – Office visits and examinations, as follows:
    - Initial or periodic oral examination; Limited to one examination in any consecutive six-month period; and
    - Emergency palliative treatment and other non-routine, unscheduled visits.
  - Fixed and removable Appliances to inhibit thumb-sucking and other harmful habits; Limited to Dependent children age 15 and younger, and further limited to the initial Appliance only. This includes all adjustments in the first six months after installation.
  - Prophylaxis and fluoride treatments; Limited to one treatment in any consecutive six-month period. This includes examination, scaling and polishing. Topical application of fluoride is limited to Dependent children age 17 and younger, and is further limited to one treatment in any consecutive six-month period. This includes examination and prophylaxis.
  - Space maintainers; Limited to Dependent children age 15 and younger, and further limited to the initial Appliance only. This includes all adjustments in the first six months after installation. Examples of space

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

maintainers include fixed unilateral, band or stainless steel crown types, fixed unilateral cast types and removable, bilateral types.

- **General Dental Services.** The following services and treatments:
  - All Medically Necessary X-rays not included under another class of eligible dental services.
  - Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures.
  - Denture adjustments; Limited to adjustments by a Dentist other than the one providing the denture, and adjustments more than six months after installation. The addition of teeth to partial dentures to replace extracted natural teeth is also considered.
  - Denture duplication jump–case; Limited to once per denture in any consecutive 36-month period.
  - Denture reline; Limited to once per denture in any consecutive 12-month period. This includes an office reline or a laboratory reline.
  - Denture repairs of acrylic or metal dentures. Repairing dentures when no teeth are damaged, repairing dentures and replacing one or more broken teeth and replacing one or more broken teeth when no other damage is present.
  - Diagnostic consultation with a Dentist other than the one providing treatment; Limited to one consultation for each dental specialty in any consecutive 12-month period. The Plan will provide benefits only if no other service is rendered during the visit.
  - Diagnostic services, including examination and diagnosis using diagnostic casts, biopsy and examination of oral tissue.
  - Endodontic services; Allowance includes routine X-rays and cultures, but excludes final restoration. Endodontic services include pulp capping, remineralization (calcium hydroxide) as a separate procedure, vital pulpotomy and apexification.
  - Extractions, including uncomplicated extraction of one or more teeth, surgical removal of erupted teeth involving tissue flap and bone removal, and surgical removal of impacted teeth.

    Note: Surgical removal of impacted wisdom teeth is included under the medical benefits of the Plan (see also "Oral surgery" in the "MEDICAL BENEFITS—BENEFITS" section).
  - Injectable antibiotics required solely for treatment of a dental condition.
  - Periodontic services, including the Treatment Plan, local anesthetics and post-surgical care. Periodontic treatment includes the following services:
    - Gingivectomy or gingivoplasty, per quadrant;
    - Gingivectomy, per tooth (fewer than six teeth);
    - Sub-gingival curettage and root planning, per quadrant (limited to a maximum of four quadrants in any consecutive 12-month period);
    - Pedicle or free soft tissue grafts, including donor sites; osseous surgery, including flap entry and closure, per quadrant;
    - Osseous surgery, including flap entry, closure and donor sites muco-gingival surgery; and
    - Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of four quadrants in any consecutive 12-month period).
  - Repairs to crowns and bridges, based on the extent and nature of damage and the type of materials involved.

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

  - Restorative services (fillings); Multiple restorations on one surface will be considered one restoration, including amalgam restorations and synthetic restorations using either silicate cement, acrylic, plastic or composite resin; crowns using acrylic, plastic or stainless steel; pins and pin retention exclusive of restorative material; and/or recementation with inlay, onlay, crown or bridge.
  - Root canal therapy of non-vital (nerve-dead) teeth, including traditional therapy and medicated paste therapy, N2 Sargenti.
  - Tissue conditioning; Limited to a maximum of two treatments per arch in any consecutive 12-month period.

- **Major Dental Services.** The following services and treatments:
  - All Medically Necessary X-rays not included under another class of eligible dental services.
  - Dental implants.
    - For Covered Persons residing within 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, the first two steps (placing of the implant and placing of the abutment) must be performed by a Carle Health & Affiliated Providers surgeon, or any oral surgeon previously approved as a Preferred Provider.
  - Dentures; benefits include all adjustments done by the Dentist furnishing the denture in the first six months after installation.:
    - Full dentures, upper and lower;
    - Partial dentures, including base, all clasps, rests and teeth;
    - Upper, with two chrome clasps with rests and an acrylic base;
    - Upper, with chrome palatal bar and clasps with an acrylic base; and
    - Lower, with two chrome clasps with rests and an acrylic base, stayplate base for upper or lower (anterior teeth only).
  - Fixed bridges (each abutment and each pontic makes up a unit in a bridge), including the following:
    - Bridge pontics: cast metal, sanitary, plastic or porcelain with metal, slotted facing and slotted pontic;
    - Bridge abutments;
    - Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics; and
    - Simple stress breakers, per unit.
  - Restorative services, cast restorations and crowns only when necessary because of decay or Injury, and only when the tooth cannot be restored with a routine filling material. Restoration services include any of the following:
    - Inlays;
    - Onlays, in addition to inlay allowance;
    - Crowns and posts made of acrylic with metal, porcelain, porcelain with metal, full cast metal (other than stainless steel);
    - 3/4 cast metal (other than stainless steel);
    - Cast post and core, in addition to crown (not a thimble coping);
    - Steel post and composite or amalgam core, in addition to a crown;
    - Cast dowel pin (one-piece cast with crown).

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

Benefits are based on the type of crown; bridge pontics, including cast metal, sanitary, plastic or porcelain with metal, slotted facing and slotted pontic; bridge abutments, removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics; and simple stress breakers, per unit.

- **Orthodontic Treatment and Appliances.** The following services and treatments:
  - Active Appliances, including diagnostic services, the Treatment Plan, the fitting, making and placing of the Active Appliance, and all related office visits including post-treatment stabilization.
  - Services or treatments listed above in the subsections "Preventive and Diagnostic Dental Services," "General Dental Services" and "Major Dental Services" in connection with orthodontic treatment.

The Plan provides benefits up to the amount shown in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS, Maximum Dental Benefits" section. Benefits are limited to Dependent children under age 26. Dental benefits include orthodontic Appliances and treatments when they are being provided to correct problems of growth and development (which may be the cause of malocclusion, periodontal disease, temporomandibular joint (TMJ) dysfunction, or combinations of these problems). The orthodontic treatment and appliances Maximum Benefit amount specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS, Maximum Dental Benefits" section applies even if there is a break in Plan coverage.

When utilizing a Treatment Plan, the Plan determines the total benefit eligible. This amount is divided into equal payments, which are spread out over the shorter of two years or the proposed length of treatment. The initial payment is made when the Active Appliance is first placed. Further payments are made at the end of each subsequent three-month period. This payment schedule is only followed if treatment is continued and the Dependent child is still covered under the Plan. Continued proof of treatment will be required.

**EXCLUDED DENTAL EXPENSES**

The Plan will not provide benefits or payment for any treatment which does not meet accepted standards of dental practice or treatment that is experimental or investigational in nature. Expenses incurred for the following items, services, supplies and treatment are specifically excluded and no benefits are payable under the Plan, unless otherwise provided herein:

- Dental services not ordered by a Physician or Dentist.
- Dental services that do not meet the standards set by the American Dental Association.
- Any Appliance or prosthetic device which is used to (1) change vertical dimension, (2) restore or maintain occlusion, except to the extent that the Plan covers orthodontic treatment, (3) splint or stabilize teeth for periodontic reasons, (4) replace tooth structure lost as a result of abrasion or attrition, and (5) treat disturbances of the temporomandibular joint (TMJ).
- Oral hygiene, dietary, plaque control and other educational programs.
- Surgical procedures, including the removal of impacted or unerupted teeth in connection with orthodontic treatment (including routine X-rays, local anesthetics and post-surgical care).
  - See also "Oral surgery" in the "MEDICAL BENEFITS—BENEFITS" section.
- Replacement of an Appliance or prosthetic device with a like Appliance or device, unless it is at least five years old and cannot be made usable, or it is damaged during an Injury while inside the patient's mouth and cannot be fixed.

## DENTAL BENEFITS

**IMPORTANT! PLEASE NOTE!**

- The Employer offers two dental Plan options, the Basic Dental Plan and the Enhanced Dental Plan. The Covered Person must understand what dental Plan option he or she selected to know which "SCHEDULE OF BENEFITS—DENTAL BENEFITS" subsection applies.
- Unless otherwise stated herein, dental benefits are subject to the Benefit Period Deductibles, Copayments and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS—DENTAL BENEFITS" section.

- Replacement of a missing, lost or stolen Appliance or prosthetic device**.**
- Cosmetic services, including, but not limited to, characterizing and personalizing prosthetic devices, making facings on prosthetic devices for any teeth in back of the second bicuspid, or bleaching or bonding of discolored teeth.
- Spare Appliances or prosthetic devices.
- Necessary treatment due to an on-the-job or job-related Injury, or a condition for which benefits are payable by workers' compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by the following: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic, (2) a facility owned or run by any governmental body, and (3) any public program, except Medicaid, paid for or sponsored by any government body. If a service is provided and the Plan is legally required to pay for the expense incurred, the Plan will pay for the services.
- Dental services obtained from a health department maintained by the Employer, a union, a trustee or a similar type of entity.
- Services that are excluded under the "PLAN EXCLUSIONS" section.
- Myofunctional therapy.
- Athletic mouthguards.
- Expenses incurred for failure to keep a scheduled visit with a Dentist.
- Travel to and from the Dentist.
- Services not specifically listed in this "DENTAL BENEFITS" section.

## SCHEDULE OF BENEFITS

## DENTAL BENEFITS

## PLAN: BASIC DENTAL PLAN OPTION

| MAXIMUM DENTAL BENEFITS | Your dental Maximum Benefit amount: |
|---|---|
| Preventive and Diagnostic Dental Services, General Dental Services and Major Dental Services, combined | $1,500 per Covered Person, per Benefit Period<br>This benefit limit does not apply to orthodontic treatment and appliances. |
| Orthodontic treatment and appliances | $1,500 per Covered Person, per Lifetime |
| Bitewing X-rays | Four films in any consecutive six-month period, per Covered Person |
| Diagnostic consultation | One consultation for each dental specialty in any consecutive 12-month period, per Covered Person |
| Topical fluoride treatment | One treatment every consecutive six-month period, per Dependent child age 17 and younger |
| Full-mouth X-rays (including panoramic film) | One series every consecutive 36-month period, per Covered Person |
| Oral exams | One exam every consecutive six-month period, per Covered Person |
| Periodontic services—sub-gingival curettage and root planning, per quadrant | A maximum of four quadrants in any consecutive 12-month period, per Covered Person |
| Periodontic services—occlusal adjustment (not involving restorations and done in conjunction with periodontic surgery), per quadrant | A maximum of four quadrants in any consecutive 12-month period, per Covered Person |
| Prophylaxis treatment (cleaning, scaling and polishing of teeth) | One treatment every consecutive six-month period, per Covered Person |
| Tissue conditioning | Two treatments per arch in any consecutive 12-month period, per Covered Person |
| Denture duplication | Once per denture in any consecutive 36-month period, per Covered Person |
| Denture relining | Once per denture in any consecutive 12-month period, per Covered Person |

| DENTAL BENEFIT DEDUCTIBLES | Your dental Deductible responsibility: |
|---|---|
| Single coverage: General Dental Services and Major Dental Services only | $50 per Benefit Period |
| Family Unit coverage: General Dental Services and Major Dental Services only | $150 per Benefit Period |
| Per Dependent child under age 26: Orthodontic Treatment and Appliances only | $50 per Lifetime |

Any combination of family members may satisfy the Family Unit dental Deductible. A new Benefit Period Deductible will apply each Benefit Period, as applicable.

## SCHEDULE OF BENEFITS

## DENTAL BENEFITS

## PLAN: BASIC DENTAL PLAN OPTION

| ELIGIBLE EXPENSES FOR DENTAL BENEFITS | You Pay: |
|---|---|
| Preventive and Diagnostic Dental Services [1] | 0% Coinsurance (dental Deductible does not apply) |
| General Dental Services [1] | 20% Coinsurance, after dental Deductible [2] |
| Major Dental Services [1] | 50% Coinsurance, after dental Deductible [2] |
| Orthodontic Treatment and Appliances [1] | 50% Coinsurance, after dental Deductible [2] |

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

[2] See the "DENTAL BENEFIT DEDUCTIBLES" subsection of this "SCHEDULE OF BENEFITS" section to determine the applicable dental Deductible amount that applies.

| PREDETERMINATION OF BENEFITS |
|---|
| Before starting a dental treatment for which the expense is expected to be $125 or more, a predetermination of benefits form may be submitted. See the "DENTAL BENEFITS" section for more information on how to submit a form for predetermination of benefits. |

**PLEASE NOTE:**

Coinsurance is based on Usual, Customary and Reasonable ("UCR") fees. In addition to the Coinsurance, the Covered Person pays any expenses in excess of the UCR amount. See the "DENTAL BENEFITS" section for details.

# SCHEDULE OF BENEFITS
# DENTAL BENEFITS
## PLAN: ENHANCED DENTAL PLAN OPTION

| MAXIMUM DENTAL BENEFITS | Your dental Maximum Benefit amount: |
|---|---|
| Preventive and Diagnostic Dental Services, General Dental Services and Major Dental Services, combined | $2,500 per Covered Person, per Benefit Period<br>This benefit limit does not apply to orthodontic treatment and appliances. |
| Orthodontic treatment and appliances | $3,000 per Covered Person, per Lifetime |
| Bitewing X-rays | Four films in any consecutive six-month period, per Covered Person |
| Diagnostic consultation | One consultation for each dental specialty in any consecutive 12-month period, per Covered Person |
| Topical fluoride treatment | One treatment every consecutive six-month period, per Dependent child age 17 and younger |
| Full-mouth X-rays (including panoramic film) | One series every consecutive 36-month period, per Covered Person |
| Oral exams | One exam every consecutive six-month period, per Covered Person |
| Periodontic services—sub-gingival curettage and root planning, per quadrant | A maximum of four quadrants in any consecutive 12-month period, per Covered Person |
| Periodontic services—occlusal adjustment (not involving restorations and done in conjunction with periodontic surgery), per quadrant | A maximum of four quadrants in any consecutive 12-month period, per Covered Person |
| Prophylaxis treatment (cleaning, scaling and polishing of teeth) | One treatment every consecutive six-month period, per Covered Person |
| Tissue conditioning | Two treatments per arch in any consecutive 12-month period, per Covered Person |
| Denture duplication | Once per denture in any consecutive 36-month period, per Covered Person |
| Denture relining | Once per denture in any consecutive 12-month period, per Covered Person |

| DENTAL BENEFIT DEDUCTIBLES | Your dental Deductible responsibility: |
|---|---|
| Single coverage: General Dental Services and Major Dental Services only | $50 per Benefit Period |
| Family Unit coverage: General Dental Services and Major Dental Services only | $150 per Benefit Period |
| Per Dependent child under age 26: Orthodontic Treatment and Appliances only | $50 per Lifetime |

Any combination of family members may satisfy the Family Unit dental Deductible. A new Benefit Period Deductible will apply each Benefit Period, as applicable.

## SCHEDULE OF BENEFITS
## DENTAL BENEFITS
## PLAN: ENHANCED DENTAL PLAN OPTION

| ELIGIBLE EXPENSES FOR DENTAL BENEFITS | You Pay: |
|---|---|
| Preventive and Diagnostic Dental Services [1] | 0% Coinsurance (dental Deductible does not apply) |
| General Dental Services [1] | 20% Coinsurance, after dental Deductible [2] |
| Major Dental Services [1] | 50% Coinsurance, after dental Deductible [2] |
| Orthodontic Treatment and Appliances [1] | 50% Coinsurance, after dental Deductible [2] |

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

[2] See the "DENTAL BENEFIT DEDUCTIBLES" subsection of this "SCHEDULE OF BENEFITS" section to determine the applicable dental Deductible amount that applies.

| PREDETERMINATION OF BENEFITS |
|---|
| Before starting a dental treatment for which the expense is expected to be $125 or more, a predetermination of benefits form may be submitted. See the "DENTAL BENEFITS" section for more information on how to submit a form for predetermination of benefits. |

**PLEASE NOTE:**

Coinsurance is based on Usual, Customary and Reasonable ("UCR") fees. In addition to the Coinsurance, the Covered Person pays any expenses in excess of the UCR amount. See the "DENTAL BENEFITS" section for details.

## HOW TO SUBMIT A CLAIM AND CLAIMS DENIAL APPEAL PROCEDURE

**NOTE:** Claims that relate solely to whether the Covered Person is eligible to participate in the Plan, and that do not involve a claim for benefits under the Plan, must be filed with, and are determined by, the Plan Administrator or its designee. (Submit eligibility claims in writing to The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section. The Plan Administrator's decisions regarding eligibility under the Plan are final, and are not subject to the Plan's appeals procedures.

Plan benefits shall be provided only if the Plan Administrator or its designee decides in its discretion that a Covered Person is entitled to them.

- To submit Preferred Provider medical Claims, see "PROVIDER NETWORK AND CLAIM SUBMISSION DETAILS" in the "GENERAL PLAN INFORMATION" section or the Plan ID Card.
- To submit Non-Preferred Provider medical Claims, see "NON-PREFERRED PROVIDER CLAIM SUBMISSION DETAILS" in the "GENERAL PLAN INFORMATION" section.
- To submit dental claims, see "DENTAL CLAIM SUBMISSION DETAILS" in the "GENERAL PLAN INFORMATION" section or the Plan ID Card.
- To submit Prescription Drug benefit Claims, see the "PRESCRIPTION DRUG BENEFITS" section or the Plan ID Card.

### TIMELY FILING OF CLAIMS

A claim for benefits will be considered timely of it is filed within 90 days of the date the expense is incurred. Benefits are based on the Plan's provisions and limitations in effect at the time the expense is incurred. Claims filed after 90 days following the incurred date may be declined or reduced unless it is not reasonably possible to submit the Claim timely, or the Claimant is not legally competent or is incapable of submitting the Claim timely. To request an extension of the timely filing period, the Claimant and/or a representative of the Claimant must follow the Plan's standard appeal process (see the "CLAIMS DENIAL APPEAL PROCEDURES" subsection below). The Claimant is encouraged to provide a reasonable explanation, in writing, and include relevant documentation of the circumstances and/or reasons the Claim was not filed timely. If practicable, the explanation may be provided in advance of, or in conjunction with, the filing of the Claim, and in no event should the explanation and related substantiation be provided later than the date stated in a request for additional information from the Plan, if such a request is made.

### CLAIMS REVIEW PROCEDURE

A request for Plan benefits will be considered a Claim for Plan benefits, and it will be subject to a full and fair review. This means that Claims will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. If a Claim is wholly or partially denied, or if coverage is rescinded retroactively for fraud or misrepresentation of a material fact, the Plan or its designee will furnish the Claimant with a written notice of this Adverse Benefit Determination, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. The notice will be stated in a manner calculated to be understood by the Claimant and will contain the following information:

**(1)** Information sufficient to allow the Claimant to identify the Claim involved including the date of service, the health care Provider, the Claim amount (if applicable);

**(2)** A statement that the diagnosis code and its corresponding meaning; and the treatment code and its corresponding meaning, along with a description of the standard that was used in denying the Claim (if any), will be provided free of charge, upon request;

**(3)** The specific reason or reasons for the Adverse Benefit Determination;

**(4)** Reference to the specific Plan provisions and limitations on which the determination was based;

**(5)** A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;

**(6)** The identification of medical or vocational experts whose advice was obtained on behalf of the Plan in

connection with an Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, or a statement that such identification will be provided free of charge upon request;

**(7)** A description of the Plan's internal appeals and external review procedures, and the time limits applicable to such procedures; This will include a statement of the Claimant's right to bring a civil action under Section 502 of ERISA following an Adverse Benefit Determination on review;

**(8)** A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;

**(9)** The statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.";

**(10)** Any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Adverse Benefit Determination (or a statement that it was relied upon and that a copy will be provided free of charge to the Claimant, upon request);

**(11)** If the Adverse Benefit Decision is based on the Medical Necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request;

**(12)** Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

**Urgent Care Claims.** Upon receipt of a Preauthorization request for Urgent Care, the Plan or its designee will notify the Claimant of the benefit determination as soon as possible, but not later than 72 hours. If sufficient information was not provided to determine benefits payable under the Plan, the Plan or its designee will notify the Claimant within 24 hours of receipt of the request. The Claimant will be provided a reasonable amount of time, but not less than 48 hours to provide the specified information. The Plan or its designee will notify the Claimant of the benefit determination within 48 hours after receipt of the requested information. The Claim will be denied if the requested information is not received within the timeframe given to provide the information. If the notification is provided orally, a written or electronic notification will be provided to the Claimant within three days after the oral notification.

**Pre-Service Claims.** Upon receipt of a Preauthorization request, the Plan or its designee will notify the Claimant of the benefit determination as soon as possible, but not later than 15 days. The Plan or its designee will notify the Claimant within the 15-day period if special circumstances require an extension of time for determining benefits. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render a decision. In no event will the extension exceed a period of 15 days from the end of the initial 15-day period. If the extension is necessary because the Claimant failed to provide information necessary to determine benefits, the Claimant will have 45 days from the receipt of notice to provide the requested information. The Claim will be denied if the requested information is not received within the timeframe given to provide the information.

**Post-Service Claims.** A Post-Service Claim will be deemed to be filed on the date that the Third Party Administrator receives a Claim. The Plan or its designee will notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days. The Plan or its designee will notify the Claimant within the 30-day period if special circumstances require an extension of time for determining benefits. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render a decision. In no event will the extension exceed a period of 15 days from the end of the initial 30-day period. If the extension is necessary because the Claimant failed to provide information necessary to determine benefits, the Claimant will have 45 days from the receipt of notice to provide the requested information. The Claim will be denied if the requested information is not received within the timeframe given to provide the information.

**Concurrent Care Claims.** Any reduction or termination by the Plan of concurrent care (other than by Plan Amendment or termination) before the end of an approved period of time or number of treatments will constitute an Adverse Benefit Determination. The Plan or its designee will notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

**Rescission of Coverage.** A Rescission of coverage for fraud or misrepresentation of a material fact will constitute an Adverse Benefit Determination. The Plan or its designee will provide the Claimant at least 30-days' advance written notice of such action to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination.

**CLAIMS DENIAL APPEAL PROCEDURE**

In cases where a Claim is wholly or partially denied, or if coverage is rescinded retroactively for fraud or misrepresentation of a material fact, the Claimant or their authorized representative (including their Physician, attorney or other health care Provider) may appeal the Adverse Benefit Determination by calling or writing the Adverse Benefit Determination Facilitator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. The request for review of a wholly or partially denied Claim must be directed to the Adverse Benefit Determination Facilitator within 180 days after receiving notification of an Adverse Benefit Determination. The request for review of a Rescission of coverage must be made within 30 days after receiving notification of the Adverse Benefit Determination.

A Claimant may submit written comments, documents, records, testimony and other information relating to the Claim. If the Claimant so requests, they will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. A document, record or other information shall be considered relevant to a Claim if it:

**(1)** was relied upon in making the benefit determination;

**(2)** was submitted, considered, or generated in the course of making the benefit determination, without regard to if it was relied upon in making the benefit determination;

**(3)** demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions and limitations have been applied consistently with respect to all Claimants; or

**(4)** constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The Plan or its designee shall provide the Claimant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge, as soon as possible, and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant to respond.

The request for a review of an Adverse Benefit Determination (appeal) will be subject to a full and fair review. The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to if such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to if a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a Health Care Professional who was not involved in the original benefit determination. This Health Care Professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

- **Post-Service Claims.** Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and provide the Claimant a written notice of the Plan's decision no later than 60 days after receipt of the request.

- **Urgent Care Claims.** Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and notify the Claimant of the decision no later than 72 hours after receipt of the request. If there is an Adverse Benefit Determination on a Claim involving Urgent Care where the time for completion of a standard appeal would seriously jeopardize the Claimant's life or the Claimant's ability to regain maximum function, the Claimant may an expedited appeal. The request for an expedited appeal may be submitted orally or in writing by the Claimant or his/her authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by phone, facsimile or other similarly expeditious method. Alternatively, the Claimant may also request an expedited external review.

  If an appeal request is denied the Claimant, his/her Physician or other health care Provider may request an expedited external review by an independent review organization by calling or writing the External Review Facilitator whose contact information can be found in the "GENERAL PLAN INFORMATION" section (see the "EXTERNAL REVIEW OF APPEALS, Expedited Medical Necessity Review" subsection) if:

  **(1)** the Claimant, his/her Physician or other health care Provider believes that the time frame for completion of an external review would seriously jeopardize the Claimant's life, health or ability to regain maximum function;

  **(2)** the Adverse Benefit Determination concerns an emergency admission, availability of care, continued stay and the Claimant has not been discharged from the facility or an ongoing treatment; or

  **(3)** the Adverse Benefit Determination of coverage is based on the determination that the requested service or treatment is experimental or investigational and the health care Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated.

- **Pre-Service Claims.** Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and provide the Claimant a written notice of the decision no later than 30 days after receipt of the request.

- **Concurrent Care Claims.** Appeals to extend concurrent care will be made in accordance with the Urgent Care Claims, Pre-Service Claims or Post-Service Claims procedures discussed above.

- **Rescission of Coverage.** Upon request for an appeal of an Adverse Benefit Determination, the Plan or its designee will review the Claim and provide the Claimant a written notice of the decision no later than 30 days after the receipt of the request.

**NOTICE OF APPEAL DETERMINATION**

The Plan or its designee will furnish the Claimant with a written or electronic notice of a benefit determination on review, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. The notice will be stated in a manner calculated to be understood by the Claimant. This written notice will contain the following information:

**(1)** Information sufficient to allow the Claimant to identify the Claim involved (including the date of service; the health care Provider; the Claim amount, if applicable);

**(2)** A statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided free of charge upon request;

**(3)** The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the Claim;

**(4)** Reference to the specific Plan provisions and limitations on which the Adverse Benefit Determination is based;

**(5)** A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of any relevant document and the statement "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and state insurance regulatory agency.";

**(6)** A statement describing the Plan's external review procedures, the time limits applicable to such procedures and a statement of the Claimant's right to bring an action under ERISA Section 502(a);

**(7)** Any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Adverse Benefit Determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request;

**(8)** If the Adverse Benefit Determination decision is based on if the treatment or service is Medically Necessary or experimental or investigational, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request, will be provided. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination, without regard to whether the advice was relied upon in making the benefit determination, will be identified; and

**(9)** Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

**EXTERNAL REVIEW OF APPEALS**

If a Claimant receives a Final Adverse Benefit Determination under the medical Plan's internal claims and appeals procedures based on medical judgment or a Rescission of coverage, or if the Plan does not follow the appeal procedures properly (except for failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant), they may request that the Claim be reviewed under the Plan's external review process. The Claimant may request an external review by writing to the External Review Facilitator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. This request must be filed in writing within four months after receipt of the Final Adverse Benefit Determination.

The following provisions apply:

**(1)** The Plan waives any right to claim that the Claimant failed to exhaust administrative remedies because the Claimant did not submit a request for an external review.

**(2)** Any statute of limitation or other defense based on timeliness is pended during the time of the external review.

**(3)** Upon request, the Plan or its designee will provide the Claimant the information necessary to make an informed judgment about requesting an external review.

**(4)** The Claimant will not be responsible for paying any fees associated with an external review.

**(5)** If an appeal is denied, the written response to the Claimant will cite the specific Plan provision(s) and limitation(s) upon which the Adverse Benefit Determination is based.

The Plan or its designee will determine if the Claim is eligible for review under the external review process. This determination is based on the following:

**(1)** The Claimant is or was covered under the Plan at the time the Claim was made or incurred;

**(2)** The Adverse Benefit Determination relates to the Claimant's failure to meet the Plan's eligibility requirements;

**(3)** The Claimant has exhausted the Plan's internal claims and appeal procedures (a Claimant may request an expedited external review under certain circumstances [see the "Expedited External Review" subsection]); and

**(4)** The Claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Plan or its designee will provide written notification to the Claimant if the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Plan or its designee will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number ((866) 444-3272).

If the request is not complete, the notice will describe the information necessary to complete it. The Claimant will have 48 hours or until the last day of the four-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the external review process, the Plan or its designee will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its Adverse Benefit Determination. If the Adverse Benefit Determination is reversed, the external review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

**(1)** the Claimant's medical records;

**(2)** the attending Health Care Professional's recommendation;

**(3)** reports from appropriate Health Care Professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating Provider;

**(4)** the terms of the Plan;

**(5)** appropriate practice guidelines;

**(6)** any applicable clinical review criteria developed and used by the Plan; and

**(7)** the opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

**(1)** a general description of the reason for the external review, including information sufficient to identify the Claim;

**(2)** the date the IRO received the assignment to conduct the review and the date of the IRO's decision;

**(3)** references to the evidence or documentation the IRO considered in reaching its decision;

**(4)** a discussion of the principal reason(s) for the IRO's decision;

**(5)** a statement that the determination is binding and that judicial review may be available to the Claimant; and

**(6)** contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

**Expedited External Review.** Generally, a Claimant must exhaust the Plan's claims and appeal procedures in order to be eligible for the external review process. However, in some cases, the Plan provides for an expedited external review if:

**(1)** the Claimant receives an Adverse Benefit Determination on a Claim that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures (i) would seriously jeopardize the Claimant's life or health or ability to regain maximum function, (ii) concerns an emergency admission, availability of care, continued stay and the Claimant has not been discharged from the facility or an ongoing treatment; or (iii) is based on the determination that the requested service or treatment is experimental or investigational and the health care Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated or

**(2)** the Claimant receives a Final Adverse Benefit Determination on an appeal that involves a medical condition where the time for completion of a standard external review process (i) would seriously jeopardize the Claimant's life or health or ability to regain maximum function, (ii) concerns an emergency admission, availability of care, continued stay or health care item or service and the Claimant has not been discharged from a facility or an ongoing treatment; or (iii) is based on the determination that the requested service or treatment is experimental or investigational and the health care Provider certifies in writing that the treatment would be significantly less effective if not promptly initiated.

Immediately upon receipt of a request for expedited external review, the Plan or its designee must determine and notify the Claimant if the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

A Claimant must exhaust the claims appeal procedures before filing a suit for benefits. In the event the Plan fails to properly follow its internal claims appeal procedures (except for failures that are based on de minimis violations that do not cause and are not likely to cause, prejudice or harm to the Claimant), the claims appeal procedures will be deemed exhausted.

## CIVIL ACTIONS UNDER ERISA

A Covered Person has a right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) after a Final Adverse Benefit Determination has been made, or if the Plan does not follow the internal appeal procedures properly. Any such action against the Plan or its fiduciaries must be filed in a court of law no later than 90 days after the Plan or the IRO makes a final decision on review of an appealed Claim. Any legal action brought for benefits under the Plan must be filed in the United States District Court, Central District of Illinois.

## DEFINITIONS FOR PURPOSES OF CLAIMS AND APPEALS

"Adverse Benefit Determination" means a denial, reduction, Rescission or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. This includes any such determination that is based on an Employee's or Dependent's eligibility to participate in the Plan or resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to not be Medically Necessary.

"Claim" means a request for benefits under the Plan made by a Claimant in accordance with the Plan's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.

"Claimant" means a Covered Person or their authorized representative (including their Physician, attorney or other health care Provider) that complies with the Plan's reasonable procedure for making benefit Claims. If the Claim is an

Urgent Care Claim, a Health Care Professional, with knowledge of the Covered Person's medical condition, will be permitted to act as the Covered Person's representative.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the Plan's internal appeals procedure or an Adverse Benefit Determination for which the Plan's internal appeals procedures are properly deemed to be exhausted.

"Health Care Professional" means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

"Plan"" means the written document used to communicate benefit provisions, limitations, rights, and obligations to persons enrolled in the Plan provided by the Plan Sponsor.

"Post-Service Claim" means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for eligible medical services already received by the Claimant.

"Pre-Service Claim" means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Preauthorization.

"Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if:

- the cancellation or discontinuance has only a prospective effect; or
- the cancellation or discontinuance is effective retroactively to the extent it is attributable to a failure to timely pay required contributions toward the cost of coverage; or
- the cancellation or discontinuance is effective retroactively due to an act or practice that constitutes fraud or an intentional misrepresentation of material fact.

"Urgent Care Claim" means any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

## COORDINATION OF BENEFITS

**Coordination of the Benefit Plans.** Coordination of benefits sets out rules for the order of payment of benefits, if determined to be Eligible Expenses, when two or more plans—including Medicare—are paying. When an Employee or Retired Employee is covered by the Plan and another plan, or the Employee's Spouse or Domestic Partner is covered by the Plan and by another plan, or the couple's Dependent children are covered by two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100 percent of the total Allowable Expenses.

**Benefit Plan.** This provision will coordinate the medical and dental benefits of a benefit plan. For purposes of this "COORDINATION OF BENEFITS" section, the term "Benefit Plan" means this Plan or any one of the following plans:

**(1)** Group and nongroup insurance contracts and subscriber contracts.

**(2)** Uninsured arrangements of group and nongroup coverage.

**(3)** Group and nongroup coverage through closed panel plans.

**(4)** Group type contracts.

**(5)** Medical care component of long term care contracts such as skilled nursing care.

**(6)** Medical benefits coverage of "no-fault automobile insurance." For purposes of this subsection, "no-fault automobile insurance" means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**(7)** Traditional automobile "fault" type contracts.

**(8)** Medicare, as permitted by law.

The term "Benefit Plan" does not include the following: hospital indemnity coverage benefits or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; or a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

**Allowable Expense.** In order for an expense to be allowable for coordination of benefits, it must be determined as an Eligible Expense under the Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans, the Plan will not consider any expenses incurred in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, the Plan will not consider as an Allowable Expense any expense incurred that would have been paid by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service-type plans where services are provided as benefits, the reasonable cash value of each service will be considered the Allowable Expense.

**Automobile limitations.** When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

**Benefit Plan payment order.** When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

**(1)** Benefit Plans that do not have a coordination provision, or one like it, will pay first. Benefit Plans with such a provision will be considered after those without one.

**(2)** Benefit Plans with a coordination provision will pay their benefits up to the Allowable Expense:

**(a)** **Non-dependent/Dependent.** The benefits of a Benefit Plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

**(b)** **Active/Inactive employee.** The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers that person as a laid-off or retired employee. The benefits of a Benefit Plan which covers a person as a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers a person as a dependent of a laid-off or retired employee. If the other Benefit Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

**(c)** **COBRA continuation coverage.** The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers the person as a COBRA beneficiary.

**(d)** **Dependent child/Parents not Legally-Separated or divorced.** When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

**(i)** The benefits of the Benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the Benefit Plan of the parent whose birthday falls later in that year;

**(ii)** If both parents have the same birthday, the benefits of the Benefit Plan which has covered the parent for the longer time are determined before those of the Benefit Plan which covers the other parent.

**(e)** **Dependent child/Parent Legally-Separated or divorced.** When a child's parents are divorced or Legally Separated, these rules will apply:

**(i)** This rule applies when the parent with custody of the child has not remarried. The Benefit Plan of the parent with custody will be considered before the Benefit Plan of the parent without custody.

**(ii)** This rule applies when the parent with custody of the child has remarried. The Benefit Plan of the parent with custody will be considered first. The Benefit Plan of the stepparent that provides benefits to the child as a dependent will be considered next. The Benefit Plan of the parent without custody will be considered last.

**(iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the Benefit Plan of that parent will be considered before other plans that cover the child as a dependent.

**(iv)** **Dependent child/Joint custody.** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans providing benefits to the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

**(v)** For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

**(f)** **Married adult Dependent child.** If a married adult Dependent child has their own coverage as a dependent under their spouse's plan and has coverage as a Dependent under either or both parent's plan, the plans covering the adult dependent child will follow the order of benefit determination rules outlined in (g) below.

**(i)** In the event that the adult Dependent child's coverage under their spouse's plan began on the same date as the adult Dependent child's coverage under either or both parent's plans, the plans covering the adult Dependent child will follow the order of benefit determination rules outlined in (d) above.

**(g)** **Longer/Shorter length of coverage:** If there is still a conflict after these rules have been applied, the benefit plan which has covered the person for the longer time will be considered first. When there is a conflict in the coordination of benefit rules, the Plan will never pay more than 50 percent of Allowable Expenses when paying secondary.

**(3)** If a Covered Person is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and the Plan will pay second.

**(4)** The Plan will pay primary to Tricare and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

**Medicare.** Medicare will pay primary, secondary or last to the extent required by federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan or its designee will make this determination based on the information available through the Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan or its designee will make reasonable assumptions based on published Medicare fee schedules.

***Medicare-Eligible Beneficiaries:*** The federal "Medicare Secondary Payer" (MSP) laws regulate how certain employers may offer group health plan benefits to Medicare-Eligible Employees and Dependents ("Beneficiaries").

Under the MSP laws, Medicare generally pays secondary to the benefits provided by the Plan. Following are some common situations when Medicare would be the secondary payer for a Medicare-Eligible Beneficiary:

- A Beneficiary with end-stage renal disease who is covered under this Plan, during the first 30 months of their Medicare eligibility or entitlement;
- A Beneficiary age 65 and older who is covered under this Plan due to their or their Spouse's current employment status with the Employer, if the Employer has 20 or more Employees;
- A disabled Beneficiary under age 65 who is covered under this Plan due to their or a family member's current employment status with the Employer, if the Employer employs more than 100 Employees.

To assist the Employer and the Plan in complying with the MSP laws, an Employee must notify the Employer promptly if they or any of their Dependents become eligible for Medicare or have Medicare eligibility terminated or changed. An Employee must also promptly and accurately complete any requests for information from the Employer concerning their or any Dependents' Medicare eligibility.

Medicare is the primary coverage for those Medicare-Eligible Beneficiaries to whom the MSP laws do not apply (for example, retired employees and their spouses who are age 65 or older). The benefits of the Plan for such Medicare-Eligible Beneficiaries do not include payment for services and items to the extent Medicare payment is available or would be available for such services or items if the Beneficiary enrolled in Medicare and made a proper claim for Medicare payment. (See "Medicare Benefits" under the "PLAN EXCLUSIONS" section for this exclusion and the "DEFINED TERMS" section for the definition of "Medicare-Eligible Beneficiary".)

To obtain the greatest benefits available under this Plan, a Medicare-Eligible Beneficiary to whom the MSP laws do not apply should:

- enroll in Part A, Part B and Part D of Medicare.

- obtain necessary health care services and items from Preferred Providers according to the terms and conditions of the Plan. For services received from a Preferred Provider, this Plan will pay for any applicable Medicare deductible and coinsurance amounts, as well as any services and items described in the "MEDICAL BENEFITS—BENEFITS" section for which Medicare does not pay.

If a Covered Person does not enroll in Part B of Medicare, they will be responsible for the portion of the bills that Medicare would have allowed under Part B coverage.

**Claims Determination Period.** Benefits will be coordinated on a Benefit Period basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make the COB provision work, the Plan may provide or obtain necessary information from another Benefit Plan, insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person claiming benefits under this Plan must provide this Plan the information it requests about other Benefit Plans and all benefits received from them.

The Plan or its designee may also request updated information from the Covered Person annually, or when information is received, that indicates a change from the information the Plan has on file, to verify or update their coordination of benefits information. Covered Persons must complete and return the request by mail to the Third Party Administrator whose address can be found in the "GENERAL PLAN INFORMATION" section, or they may call customer service at the phone number on the Plan ID Card, to respond to these requests. If no response is received within 45 days from the Covered Person's receipt of the request of information, the Covered Person's claim(s) will be denied.

**Facility of Payment.** The Plan may repay other Benefit Plans for benefits paid that the Plan or its designee determines the Plan should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** The Plan may pay benefits that should be paid by another Benefit Plan. In this case, the Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan. Further, the Plan may pay benefits that are later found to be greater than the Allowable Expense. In this case, the Plan may recover the amount of the overpayment from the source to which it was paid.

**Exception to Medicaid.** In accordance with ERISA, if ERISA applies to the Plan, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

# SUBROGATION AND THIRD PARTY RECOVERY PROVISIONS

## RIGHT OF SUBROGATION AND REFUND/RECOVERY

**When this provision applies.** The Covered Person may incur health care expenses due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the health care expenses. Accepting benefits under the Plan for those incurred health care expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for health care expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

**(1)** automatically assigns to the Plan their rights against any Third Party or insurer when this provision applies; and

**(2)** must repay to the Plan the benefits paid on their behalf out of the Recovery made from the Third Party or insurer.

**Amount subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100 percent, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-health care expenses, attorney fees, or other costs and expenses. Accepting benefits under the Plan for those incurred health care expenses automatically assigns to the Plan any and all rights the Covered Person may have to Recover payments from any responsible Third Party. Further, accepting benefits under the Plan for those incurred health care expenses automatically assigns to the Plan the Covered Person's Third Party claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for health care expenses as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan has to file suit in order to Recover payment for health care expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is necessary to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

**Conditions Precedent to Benefits.** The Plan shall have no obligation whatsoever to pay a Covered Person's health care expenses if the Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any health care expenses incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or their authorized legal representative obtains valid court recognition and approval of the Plan's 100 percent, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

## SUBROGATION AND THIRD PARTY RECOVERY PROVISIONS

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.

**DEFINITIONS FOR PURPOSES OF SUBROGATION AND THIRD PARTY RECOVERY**

"Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect health care expenses that are eligible under the Plan. "Recoveries" further includes, but is not limited to, recoveries for health care expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for health care benefit expenses that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for health care expenses against the other person.

"Third Party" means any Third Party including another person or a business entity.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain individuals covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end under certain circumstances called "Qualifying Events". This notice is intended to inform those individuals, in summary fashion, of their rights and obligations under the continuation coverage provisions and limitations of COBRA, as amended and reflected in final and proposed regulations published by the U.S. Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage for the Plan is administered by the COBRA Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to individuals who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain individuals who lose coverage (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage (including the Preferred Provider Network) that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly-situated Active Employees who have not experienced a Qualifying Event (in other words, similarly-situated non-COBRA beneficiaries).

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary is considered to be any of the following:

**(1)** Any individual who, on the day before a Qualifying Event, is enrolled in the Plan by virtue of being on that day either an Employee, the Spouse of an Employee, or a Dependent child of an Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

**(2)** Any child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, and any individual who is enrolled in the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

**(3)** An Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such an Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as an Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States of America. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Partners who do not qualify as the Employee's or Retired Employee's tax dependent under IRS rules are **not** considered Qualified Beneficiaries. However, the Plan will treat a Domestic Partner as a Qualified Beneficiary if they are enrolled in the Plan on the day before a Qualifying Event. For purposes of interpreting this section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner the contractual rights outlined in this section but does not extend statutory remedies to the Domestic Partner.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

Each Qualified Beneficiary (including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A "Qualifying Event" means the occurrence of a certain event that would cause an individual to lose their health coverage under the Plan. The type of Qualifying Event determines who the Qualified Beneficiaries are and the amount of time that the Plan must offer COBRA continuation coverage to them. A Qualifying Event is considered any of the following if the Plan Administrator provided that the individual would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

**(1)** The death of an Employee or Retired Employee.

**(2)** The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of an Employee's employment.

**(3)** The divorce or legal separation of an Employee or Retired Employee from the Employee's or Retired Employee's Spouse. If the Employee or Retired Employee reduces or eliminates the Employee's or Retired Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

**(4)** An Employee's or Retired Employee's enrollment in any part of the Medicare program.

**(5)** A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

**(6)** A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment an Employee retired at any time.

If the Qualifying Event causes the Employee, or the Spouse or a Dependent child of the Employee or Retired Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by an Employee, or the Spouse, or a Dependent child of the Employee or Retired Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the date the leave begins.

**What factors should be considered when deciding if you will elect COBRA continuation coverage?** When considering options for health care coverage, Qualified Beneficiaries should consider the following:

- **Coverage premiums.** The Plan can charge up to 102 percent of total Plan premiums for COBRA continuation coverage. Other options, like coverage through a Spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). Qualified Beneficiaries have the right to request special enrollment in another group health plan for which

they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider networks.** If a Qualified Beneficiary is currently receiving care or treatment for a condition, a change in health care coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network when considering other health care coverage.

- **Drug formularies.** For Qualified Beneficiaries taking medication, a change in health care coverage may affect costs for medication and, in some cases, the medication may not be payable by another plan. Qualified Beneficiaries should check to see if current medications are listed in drug formularies for other health care coverage.

- **Severance payments.** If COBRA rights arise because the Employee has lost their job and there is a severance package available from the Employer, the former Employer may have offered to pay some or all of the Employee's COBRA premium payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the U.S. Department of Labor at (866) 444-3272 to discuss options.

- **Medicare eligibility.** A Qualified Beneficiary should be aware of how COBRA continuation coverage coordinates with Medicare eligibility. If a Qualified Beneficiary is eligible for Medicare at the time of the Qualifying Event, or if the Qualified Beneficiary will become eligible soon after the Qualifying Event, the Qualified Beneficiary should be aware that they have eight months to enroll in Medicare after their employment-related health coverage ends to avoid late enrollment penalties and gaps in coverage. Electing COBRA continuation coverage does not extend this eight-month period. Also of note: if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued by the Plan due to Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage. If you become entitled to Medicare Part A or B after you elect COBRA continuation coverage, the Plan may terminate your COBRA continuation coverage. For more information, visit medicare.gov/sign-up-change-plan.

- **Service areas.** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the service or coverage area.

- **Other cost-sharing requirements.** In addition to premiums or contributions for health care coverage, the Plan requires individuals to pay Deductibles, Copayments, Coinsurance or other amounts as benefits are used. Qualified Beneficiaries should check to see what the cost-sharing requirements are for other health care coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

- **Other considerations:**

  **There may be other options available when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace ("Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally does not accept late entrants.

  **Are there other coverage options available besides COBRA continuation coverage?** Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or another group health plan (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Qualified Beneficiaries can learn more about many of these options by visiting www.healthcare.gov.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is considered timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of their right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If an Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and their Dependents have not elected COBRA continuation coverage within the normal election period, a second opportunity to elect COBRA continuation coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that they and/or their family members may qualify for assistance under this special provision should contact the COBRA Administrator for further information. If COBRA continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

**Is an Employee, Retired Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

**(1)** the end of employment or reduction of hours of employment,

**(2)** death of the Employee or Retired Employee,

**(3)** commencement of a proceeding in bankruptcy with respect to the Employer, or

**(4)** entitlement of the Employee or Retired Employee to any part of Medicare.

**What are the notice procedures for other Qualifying Events?** For the other Qualifying Events, such as divorce or legal separation of the Employee/Retired Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child, you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

Any notice that you provide must be **in writing**. Oral notice, including notice by phone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include the following:

- The **name of the Plan or Plans** under which you lost or are losing coverage;
- The **name and address of the Employee or Retired Employee or former Employee** who is or was enrolled in the Plan;
- The **name(s) and address(es) of all Qualified Beneficiary(ies) who lost or is/are losing coverage**; and
- The **Qualifying Event** and the **date** it occurred.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts (for example, in order to qualify for a disability extension).

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, the Plan Administrator or its designee will notify the COBRA Administrator and COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Employees or Retired Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost, or the date of Qualifying Event. If COBRA continuation coverage is not elected within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

**Is COBRA continuation coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. However, a Qualified Beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, they become entitled to Medicare or become covered under other group health plan coverage.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

**(1)** The last day of the applicable maximum coverage period.

**(2)** The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

**(3)** The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee or Retired Employee.

**(4)** The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either Part A or Part B, whichever occurs earlier).

**(5)** In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

**(a)** (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

**(b)** the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate the COBRA continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan terminates the coverage of similarly situated non-COBRA beneficiaries for cause, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as described below:

**(1)** In the case of a Qualifying Event that is an Employee's termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

However, in the case of an individual receiving Plan coverage during a leave of absence pursuant to the provisions and limitations specified in the "ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS—TERMINATION OF COVERAGE" section, under the "Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff" or the "Continuation During Family and Medical Leave" subsections, the maximum coverage period for medical Plan benefits is measured from the date the individual would otherwise lose coverage under the extended coverage provisions as described in those subsections.

Notwithstanding the foregoing, when individuals receiving long-term disability benefits under the Carle Long-Term Disability Plan cease to be eligible for medical and dental Plan benefits, as described in the "ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS—TERMINATION OF COVERAGE" section, under the "Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff—For FMLA-protected leave or disability leave only" subsection, such individuals will be eligible to elect COBRA continuation coverage and the maximum coverage period for medical and dental benefits under COBRA, as applicable, is measured from those dates.

**(2)** In the case of an Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Employee ends on the later of:

**(a)** 36 months after the date the Employee becomes enrolled in the Medicare program; or

**(b)** 18 months (or 29 months, if there is a disability extension) after the date of the Employee's termination of employment or reduction of hours of employment.

**(3)** In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

**(4)** In the case of a Qualified Beneficiary who is a child born to or placed for adoption with an Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

**(5)** In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36

months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of an Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is:

- within the first 18 months of COBRA continuation coverage; and
- within 60 days after the latest of:
  - the date of the Social Security Administration's disability determination;
  - the date of the Employee's termination of employment or reduction of hours; or
  - the date on which the Qualified Beneficiary loses (or would lose coverage) under the terms of the Plan as a result of the Employee's termination of employment or reduction or hours.

This notice must also be sent to the COBRA Administrator in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102 percent of the applicable premium and up to 150 percent of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** For purposes of this "CONTINUATION OF COVERAGE RIGHTS UNDER COBRA" section, "Timely Payment" means a payment made no later than 30 days after the first day of the COBRA continuation coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either, under the terms of the Plan, Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of COBRA continuation coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" means 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10 percent of the required amount.

**Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the

Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**IF YOU HAVE QUESTIONS**

If you have questions about COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act (PPACA), the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/agencies/ebsa.

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

# GENERAL PLAN ADMINISTRATION INFORMATION

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**Plan Administrator and Plan Sponsor.** The Carle Foundation has been delegated the authority to act as the Plan Administrator with the discretionary authority to administer the Plan.

The Carle Foundation Employees' Health and Dental Plan is the benefit plan of The Carle Foundation. The Plan Administrator shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of the Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms, provisions and limitations of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

**Powers and Duties of the Plan Administrator.** The Plan Administrator will have the powers and duties of the general administration of the Plan, including but not limited to, the following:

**(1)** To administer the Plan in accordance with its terms.

**(2)** To determine all questions of eligibility, status, and coverage under the Plan.

**(3)** To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms.

**(4)** To make factual findings.

**(5)** To decide disputes that may arise relative to a Covered Person's rights and/or availability of benefits.

**(6)** To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials, except as prohibited by applicable law.

**(7)** To keep and maintain the Plan documents and all other records pertaining to the Plan.

**(8)** To appoint and supervise a Third Party Administrator to pay claims.

**(9)** To perform all necessary reporting as required by ERISA or other applicable law.

**(10)** To establish and communicate procedures to determine if a medical child support order is qualified under ERISA Sec. 609 or other applicable law.

**(11)** To delegate to any person or entity such powers, duties and responsibilities, including discretionary authority, as it deems appropriate.

**(12)** To establish one or more committees to assist in administration of the Plan.

**(13)** To perform each and every function necessary for or related to the Plan's administration.

**Plan Administrator Compensation.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**Fiduciary.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**Fiduciary Duties.** A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to the Employees, Retired Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

**(1)** with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

**(2)** by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

**(3)** in accordance with the Plan documents to the extent that they agree with ERISA.

**The Named Fiduciary.** A "named fiduciary" is the one named in the Plan. (See the "GENERAL PLAN INFORMATION" section for the named fiduciary.) A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

**(1)** the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

**(2)** the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**Third Party Administrator is Not a Fiduciary.** A Third Party Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator; however, the Third Party Administrator has accepted a limited role relating to making determinations on appeals of adverse benefit determinations.

**Compliance with HIPAA Privacy Standards.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access, subject to the following:

**(1)** **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this "Compliance with HIPAA Privacy Standards" subsection is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

**(2)** **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and healthcare operations. The terms "payment" and "healthcare operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Healthcare operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of healthcare providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of Genetic Information will not be used or disclosed for underwriting purposes.

**(3)** **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this "Compliance with HIPAA Privacy Standards"

subsection, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

**(a)** **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

**(b)** **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.

**(c)** **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including the following:

**(i)** Investigation of the incident to determine if the breach occurred inadvertently, through negligence, or deliberately; if there is a pattern of breaches; and the degree of harm caused by the breach;

**(ii)** Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

**(iii)** Mitigating any harm caused by the breach, to the extent practicable; and

**(iv)** Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

**(4)** **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

**(a)** not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

**(b)** ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

**(c)** not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

**(d)** report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

**(e)** make available Protected Health Information to individual Plan participants in accordance with Section 164.524 of the Privacy Standards;

**(f)** make available Protected Health Information for amendment by individual Plan participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

**(g)** make available the Protected Health Information required to provide any accounting of disclosures to individual Plan participants in accordance with Section 164.528 of the Privacy Standards;

**(h)** make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

**(i)** if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer required for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

**(j)** ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

See "PERSONS AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION (PHI) UNDER THE PLAN" in the "GENERAL PLAN INFORMATION" section for a list of the Employer's designees who are authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan.

**Compliance with HIPAA Electronic Security Standards.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

**(1)** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

**(2)** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

**(3)** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in provisions (3) Authorized Employees and (4) Certification of Employers of the"Compliance With HIPAA Privacy Standards" subsection described above.

**Cost of the Plan Coverage, Funding the Plan and Payment of Benefits.**

- **Cost of the Plan Coverage.** The Plan Sponsor and the Employer share the cost of providing Plan benefits with the enrolled Covered Persons.

  The required contribution amounts are set by the Plan Sponsor and a schedule of those amounts is distributed periodically to communicate the applicable contribution amounts. The Plan Sponsor reserves the right to change the level of required contributions.

  The Employer reserves the right to assess an additional contribution for users of tobacco and similar products. Details about amounts applicable for this purpose are published with the new enrollment and Open Enrollment benefit materials.

  COBRA participants must pay the entire cost of the COBRA coverage under the Plan as set forth in the "CONTINUATION COVERAGE RIGHTS UNDER COBRA" section.

- **Funding the Plan.** The Plan is self-funded and the cost of benefits provided under the Plan is funded as follows: Funding is derived from the general assets of the Plan Sponsor and the Employer and contributions made by the enrolled Covered Persons.

- **Payment of Benefits**—Benefits are paid directly from the Plan through the Third Party Administrator.

**PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

# GENERAL PLAN ADMINISTRATION INFORMATION

## AMENDING AND TERMINATING THE PLAN

The Employer intends to maintain the Plan indefinitely. However, the Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any). The CEO, and the Executive Vice President and Chief Financial Officer of The Carle Foundation, respectively, each have the authority to prepare or cause to be prepared and to adopt an Amendment to the Plan if such Amendment is either: (1) required by law to be included in the Plan, or (2) not material (i.e., not expected to increase the cost of the Plan to the Plan Sponsor and/or to any Employer by more than one million dollars per year).

**If the Plan is Terminated.** If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. The Employer may terminate the Plan at any time. All previous contributions made by the Employer and/or Employees will continue to be issued for the purpose of paying benefits for valid claims incurred before termination or for providing similar health benefits to Covered Persons, until all contributions are exhausted.

The Plan will terminate at 11:59 p.m. on the effective date of termination as determined by the Plan Administrator. The Plan is not liable for arranging for the provision of replacement coverage or for any expenses incurred after the effective date of termination.

## ASSIGNMENT OF BENEFITS AND PAYMENT OF CLAIMS

The Plan has the right to make any benefit payment either to the Covered Person or directly to the Provider of services. The Plan or its designee is specifically authorized by the Covered Person to determine to whom benefit payments will be made. A Covered Person's claim for benefits under the Plan is expressly non-assignable and non-transferrable by a Covered Person, in whole or in part, to any person or entity, including any Provider, at any time before or after benefits for Eligible Expenses are rendered to a Covered Person.

A Covered Person shall not, at any time, either during the time in which they are a Covered Person enrolled in the Plan, or following their termination as a Covered Person, in any manner, have any right to assign their right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which they may have against the Plan or its fiduciaries.

## CLAIMS MISTAKENLY PAID

The Third Party Administrator, on behalf of the Plan, shall have the right to recover any payment which has been mistakenly paid on behalf of a Covered Person. A payment by the Third Party Administrator in accordance with the Plan is not an admission by the Plan or Third Party Administrator that the charges with respect to a claim for benefits are eligible for benefits under the Plan.

## CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

## 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.

# GENERAL PLAN ADMINISTRATION INFORMATION

## CROSS-PLAN OFFSETTING

The Plan shall participate in the Third Party Administrator's cross-plan offsetting program. The cross-plan offsetting program refers to an additional process to recover overpayments made by a self-funded group health plan to a health care Provider by withholding the overpaid amount from subsequent payment(s) to be made to the same Provider for another person who receives benefits under a different group health plan for which the Third Party Administrator is also acting in the capacity of third party administrator. The two group health plans may be wholly unrelated to each other. The purpose of the cross-plan offsetting program is to lower overall costs and expenses to both plans involved in the program.

## FACILITY OF PAYMENT

In the absence of a request for payment from a Legal Guardian or other legally-appointed representative, the Third Party Administrator may, at its option, make direct payment to the individual or institution appearing to have assumed custody of a Covered Person who is a minor or is not competent to give a valid receipt for payment of any benefit due them under the Plan.

If a Covered Person dies and benefits remain unpaid, the Third Party Administrator may, at its option, direct payments to the healthcare Provider rendering the service for which benefits are due, or to the Covered Person's surviving spouse, child(ren) share and share alike, or if none, to the executor(s) or administrator(s) of the Covered Person's estate. In the event any question or dispute shall arise as to the proper person or persons to whom any payment shall be made, the Plan Administrator may direct the Third Party Administrator to withhold such payment until there shall have been made satisfactory adjudication of such question or dispute, or until the Plan Administrator and the Third Party Administrator have been fully protected against loss by means of such indemnification, agreement or bond as it determines to be adequate.

## INVALID PROVISION

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

## MEDICAL EXAMINATION

The Plan shall have the right, through a Physician of its choice, to examine a Covered Person as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law. The Plan shall be entitled to receive any and all reports regarding such examinations or autopsies.

## MINOR OR INCOMPETENCY

If a Covered Person is a minor or, in the opinion of the Plan, not competent to give a valid receipt for payment of any benefit due them under the Plan, and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of that person, the Plan may, at its option, make direct payment to the individual or institution appearing to the Plan to have assumed the custody or the principal support of that person.

## RIGHT TO RECOVERY

If a claim is mistakenly paid or if the total payments made by the Plan as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Plan shall have the right to recover the extra amount of such payments from one or more of the following, as the Plan will determine: any person to, for or with respect to whom such payments were made, any other insurance companies, any other health plan, and any other organizations.

## GENERAL PLAN ADMINISTRATION INFORMATION

### TIME LIMITATIONS

If any limitations provided in the Plan for giving notice of claims, furnishing proof of loss or for bringing any action at law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

## COVERED PERSONS' RIGHTS UNDER ERISA

Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

- Receive information about the Plan and benefits.
- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for a Covered Person if there is a loss of coverage under the Plan as a result of a Qualifying Event. Covered Persons may have to pay for such coverage.
- Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.
- Receive a summary of the Plan's annual financial report, if an annual report is required. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

If a Covered Person's claim for a benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in state or federal court.

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, they may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons. No one, including the Employer or any other person, may fire an individual or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising their rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order them to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, they should contact the Plan Administrator. If the Covered Person has any questions about this statement or their rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your phone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# NOTICES

## NON-ENGLISH LANGUAGE NOTICE

The Plan contains, in English, a summary of a Covered Person's Plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of the Plan, they may contact the Plan Administrator or 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.

## ALTERNATIVE MEANS OF COMMUNICATION

The Plan will provide alternative means of communication when required or reasonable.

## BE AWARE OF PLAN REQUIREMENTS

The Plan contains requirements, including but not limited to notification, Preauthorization, and use of Preferred Providers and Extended Network Providers, which must be followed to obtain certain benefits or to have access to the highest benefit level. Failure to follow the requirements may affect benefits available and in some cases, benefits may not be available at all. **Read the Plan carefully** and contact customer service at the phone number on the Plan ID Card when you have questions.

## MEDICAL NECESSITY AND APPROPRIATENESS OF CARE

The Plan will provide benefits for health care service expenses only if the services provided are determined to be Medically Necessary and appropriate for the treatment, maintenance or improvement of the Covered Person's health. Benefits for preventive care services will be provided based on established standards of care.

## NOTIFICATION OF PLAN ADMINISTRATOR

Unless a different timeframe for notice is specifically provided herein, an Employee or Dependent or other Covered Person, must notify the Plan Administrator or its designee within 31 days of any event that would cause such person to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit unless the Plan otherwise specifically provides for a longer notice provision. The foregoing includes but is not limited to the following:

- Notifying the Plan Administrator or its designee of other coverage that is becoming effective or is terminating, including but not limited to individual health plans, groups health plans and Medicare;
- Notifying the Plan Administrator or its designee of an address change within 31 days of such change; and
- Notifying the Plan Administrator or its designee of a name change within 31 days of such change.

## NEWBORNS AND MOTHERS HEALTH PROTECTION ACT OF 1996

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

# NOTICES

## WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

## PROVIDER NONDISCRIMINATION

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

## RIGHT TO SELECT A WOMAN'S PRINCIPAL HEALTH CARE PROVIDER

Female Covered Persons are allowed to select a "Woman's Principal Health Care Provider" in addition to their selection of a Primary Care Physician (PCP). For the definition of "Woman's Principal Health Care Provider", see the "DEFINED TERMS" section. A Woman's Principal Health Care Provider may be seen for care without referrals from their PCP. If a Covered Person has not already selected a Woman's Principal Health Care Provider, she may do so at any time. The Covered Person is not required to have or to select a Woman's Principal Health Care Provider.

The Covered Person's Woman's Principal Health Care Provider must be a Preferred Provider. The Covered Person may obtain a list of participating obstetricians, gynecologists, and family practice specialists by visiting the Third Party Administrator's website whose address can be found in the "GENERAL PLAN INFORMATION" section. A paper copy of the Provider Directory will be provided upon request, free of charge. To designate a Woman's Principal Health Care Provider, the Covered Person may 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.

In the event the Plan requires the PCP and Woman's Principal Health Care Provider to have a referral arrangement with each other and they do not have such an arrangement, the Covered Person must select a different PCP who has a referral arrangement with her Woman's Principal Health Care Provider or select a Woman's Principal Health Care Provider who has a referral arrangement with her PCP.

## COVERED PERSONS' RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

This subsection applies for Plan Years beginning on or after January 1, 2022. Federal law requires that Covered Persons (referenced as "you" and "your" in this subsection) be provided the following notice. Note that your health plan may refer to "in-network" as "Preferred Provider" and "out-of-network" as "Non-Preferred Provider".

### Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or treatment by an out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from surprise billing or balance billing.

**What is "balance billing" (sometimes called "surprise billing")?** When you see a doctor or other health care Provider, you may owe certain out-of-pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. You may have other costs or have to pay the entire bill if you see a Provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes Providers and facilities that have not signed a contract with your health plan. Out-of-network Providers may be permitted to bill you for the difference between what your health plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual Out-of-Pocket Maximums.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—for example, when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network Provider.

**You are protected from balance billing for:**

- **Emergency Services:** If you have an Emergency Medical Condition and receive Emergency Services from an out-of-network Provider or facility, the most the Provider or facility may bill you is your health plan's in-network cost-sharing amount (such as Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may receive after you are in stable condition, unless you provide written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network Hospital or Ambulatory Surgical Center:** When you receive services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those Providers may bill you is your health plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you receive other services at these in-network facilities, out-of-network Providers cannot balance bill you, unless you provide written consent and give up your protections.
- In the event state law surprise billing requirements are applicable, they may provide additional protections.

**You are never required to give up your protections from balance billing. You also are not required to obtain care out-of-network. You can choose a Provider or facility in your health plan's network.**

**When balance billing is not allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (e.g., the Copayments, Coinsurance, and Deductibles that you would pay if the Provider or facility was in-network). Your health plan will pay out-of-network Providers and facilities directly.
- Your health plan generally must:
  - Provide benefits for Emergency Services without requiring you to get approval for services in advance (prior authorization).
  - Provide benefits for Emergency Services received by out-of-network Providers.
  - Base what you owe the Provider or facility (cost-sharing) on what it would pay an in-network Provider or facility and show that amount in your Explanation of Benefits (EOB).
  - Count any amount you pay for Emergency Services or out-of-network services toward your Deductible and Out-of-Pocket Maximums.

**If you have questions about how your claim was processed or need help reviewing a claim for surprise medical billing protections,** please contact the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section.

**If you believe you have been incorrectly billed,** you may contact the federal No Surprises Help Desk at (800) 985-3059. Visit www.cms.gov/nosurprises for more information about your rights under federal law.

See also "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES" at the end of the "MEDICAL BENEFITS" section.

# NOTICES

## CARLE FOUNDATION WELLNESS PROGRAM ("WELLNESS PROGRAM")

The Employer may make certain wellness initiatives available through the Wellness Program to individuals employed by the organization (or its subsidiaries), including individuals who are not eligible to enroll for coverage under The Carle Foundation Employees' Health and Dental Plan ("Plan"). The Employer will separately communicate the details of the Wellness Program initiatives from time to time.

Individuals who do not meet the eligibility requirements of, or who are not enrolled in, the Plan are not eligible for any benefits under the Plan, including but not limited to the preventive care benefits. However, individuals who are not eligible or who do not enroll in the Plan may be eligible for certain Wellness Program initiatives such as a biometric screening.

By offering participation in the Wellness Program, the Employer is committed to helping participating individuals achieve their best health. In the event that a Wellness Program initiative is made available that requires the individual to meet a standard related to a health factor in order to earn a reward, and the individual is unable to meet the standard for the reward, then they may qualify for an opportunity to earn the same reward by different means. Contact The Carle Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section to discuss possible alternatives. The Carle Human Resources Department personnel will work with the individual (and if the individual directs, their Physician) to find an alternative wellness initiative appropriate for their health status with the same reward.

## TOBACCO USER SURCHARGE

If a Covered Person is enrolled in medical and Prescription Drug benefits under the Plan, then they will be subject to a tobacco user premium surcharge if they uses tobacco products. Tobacco products include the following: cigarettes, cigars, pipes, smokeless tobacco, and any other product manufactured from tobacco and intended for use by smoking, inhalation, chewing, sniffing or sucking. Electronic devices such as e-cigarettes, which contain nicotine, are also subject to the tobacco user premium surcharge.

The Plan is committed to helping Covered Persons achieve or maintain their best health. **Covered Persons can avoid the tobacco user premium surcharge in one of two ways:**

**(1)** If a Covered Person (includes all enrolled Dependents if Dependent coverage is elected) does not use tobacco products, they may indicate their non-tobacco user status when they enroll for Plan coverage, and they will not be subject to the surcharge. If a Covered Person later begins using tobacco products, they must notify the Plan Administrator immediately of the change in their non-tobacco status.

**(2)** If a Covered Person uses tobacco products, they may still avoid the tobacco user surcharge by completing a Plan-designated tobacco cessation program available at no cost. A Covered Person who uses tobacco products and completes the Plan-designated tobacco cessation program will not be subject to the tobacco user surcharge as of the date of completion of the tobacco cessation program. **It is the Covered Person's responsibility to notify The Carle Foundation Human Resources Department of the completion of the program.**

If the Covered Person's Physician states, in writing, that the tobacco cessation program is not medically appropriate for them, please contact The Carle Foundation Human Resources Department whose contact information can be found in the "GENERAL PLAN INFORMATION" section for assistance; the Plan will work with the Covered Person's Physician, if the Covered Person wishes, to find an accommodation that is right for them in light of their health status and provide them with the same opportunity to avoid the tobacco user surcharge.

## DEFINED TERMS

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

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

**Active Appliance** means any appliance (such as braces) used in orthodontic services to move teeth.

**Active Employee** means an Employee of the Employer who is a member of a group or classification of Employees to whom benefits under the Plan have been extended and continue to be extended by designation of the Employer.

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

**Amendment** means a separate document attached to the Plan that adds, modifies or deletes existing terms, provisions and limitations of the Plan.

**Appliance** means any dental device other than a dental prosthetic device.

**Benefit Period** means the pre-established period of time on which the Plan's cost sharing accumulators, including but not limited to Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximums and other similar cost sharing provisions and limitations, are calculated. See the "GENERAL PLAN INFORMATION" section for the Plan's Benefit Period.

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

**Coinsurance** means a percentage of a charge a Covered Person must pay directly to the Provider for services rendered to a Covered Person by the Provider. See also the "SCHEDULE OF BENEFITS" sections.

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

**Copayment** means a specific dollar amount a Covered Person must pay for certain eligible services at the time and place a Covered Person receives such services. See also the "SCHEDULE OF BENEFITS" sections.

**Covered Person** (also sometimes referred to as "you" or "your" in this document) means an Active Employee, Retired Employee or Dependent who is enrolled in the Plan. In certain situations, a Covered Person also means a former Active Employee or former Dependent who is enrolled in the Plan.

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

**Deductible** means a set amount that must be paid by a Covered Person before the Plan begins to share in the cost of Eligible Expenses. A new Deductible applies each Benefit Period. (See the sections "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, BENEFIT PERIOD DEDUCTIBLES" and "SCHEDULE OF BENEFITS—DENTAL BENEFITS, DENTAL BENEFIT DEDUCTIBLES".)

**Dentist** means a duly licensed Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.) practicing within the scope of the dental profession and any other Physician furnishing any dental services which such Physician is licensed to perform.

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

At any time, the Plan may require documentation of a Dependent's eligibility for coverage under the Plan.

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

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

**Eligible Expense(s)** means expenses incurred for services, supplies and/or treatment if determined to be Medically Necessary, subject to all Plan provisions, limitations and requirements.

If the Plan provides dental benefits (defined), then "Eligible Expense" shall include the word, "dental" when the word "medical" is used and "dentally" when the word "medically" is used when context clearly indicates such applicability.

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

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act, Emergency Medical Treatment and Labor Act (EMTALA)) within the capability of the Hospital emergency department. This includes routine ancillary services to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient. "Stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

<u>The following applies for Plan Years beginning on or after January 1, 2022</u>: See also "Emergency Services" in the "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES—DEFINITIONS FOR PURPOSES OF SURPRISE MEDICAL BILLING PROTECTIONS" section.

**Employee** means a person who is a regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. If an individual is not considered to be an Employee of the Employer for purposes of employment taxes and wage withholding, a subsequent determination by the Employer, any governmental agency or court that the individual is a common law employee of the Employer, even if such determination is applicable to prior years, will not have a retroactive effect for purposes of eligibility to participate in the Plan for such prior years. The term "Employee" also includes any person for whom the Employer has a responsibility to provide coverage pursuant to a contractual agreement or court order.

**Employer** means The Carle Foundation which includes the following entities which have been designated as participating in the Plan:

- The Carle Foundation Hospital;
- Carle Holding Company, Inc.;
- Carle Health Care Incorporated d/b/a Carle Physician Group;
- Carle West Physician Group, Inc.;
- Hoopeston Community Memorial Hospital d/b/a Carle Hoopeston Regional Health Center;

- Carle BroMenn Medical Center;
- Carle Eureka Hospital;
- Richland Memorial Hospital, Inc. d/b/a Carle Richland Memorial Hospital; and
- At the discretion of The Carle Foundation: other Carle affiliates and subsidiaries.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

**Extended Network Provider** means a Physician or Provider that has entered into a valid contract either directly with the Plan Sponsor or through Health Alliance to access a leased network arrangement to provide health care services to Covered Persons.

Expenses incurred when using an Extended Network Provider will be considered at the Preferred Provider benefit level if:

**(1)** the Covered Person resides outside 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, or

**(2)** the Covered Person resides within 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, **and** has obtained Preauthorization to use the Extended Network Provider **in advance** of using the Extended Network Provider.

See also "Health Alliance Network" under the definition of "Network" below.

*An Extended Network Provider is not responsible for obtaining required Preauthorization on a Covered Person's behalf. The Covered Person is responsible for ensuring that required Preauthorization is completed **in advance** of incurring expenses for use of Providers or treatment/services that require Preauthorization.*

To determine if a Physician or Provider is an Extended Network Provider, Covered Persons may log onto the Third Party Administrator's website as a member to view the Plan's Network Provider Directory(ies) or contact the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. NOTE that the terminology used on the website may not mirror the terminology used in the Plan.

**Family Unit** means the Employee or Retired Employee and the family members who are enrolled as Dependents in the Plan. In certain situations, Family Unit also means the former Employee and the former family members who are enrolled as Dependents in the Plan.

**Formulary** means a list of generic drugs, brand name drugs and Specialty Prescription Drugs that when selected will lower out-of-pocket costs. See "Prescription Drug Formulary" in the "PRESCRIPTION DRUG BENEFITS" section for detailed information.

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

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

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

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

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

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

**Infertility** means a disease, condition, or status characterized by (1) a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility; (2) a person's inability to reproduce either as a single individual or with a partner without medical intervention; or (3) a licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

**Late Entrant** means an individual who enrolls in the Plan at a time other than

- when first eligible to enroll; or
- during a Special Enrollment Period.

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

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

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

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

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

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

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

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

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

**(6)** The Usual, Customary and Reasonable Charge.

The following applies for Plan Years beginning on or after January 1, 2022: See also "Maximum Allowable Charge" and "Usual, Customary and Reasonable Charge" in the "SURPRISE MEDICAL BILLING PROTECTIONS FOR

CERTAIN SERVICES—DEFINITIONS FOR PURPOSES OF SURPRISE MEDICAL BILLING PROTECTIONS" section.

**Maximum Benefit** means the total benefits available to Covered Persons for certain services, supplies or treatment, if determined to be Eligible Expenses, as specified in the "SCHEDULE OF BENEFITS" sections.

**Medical Director** means a licensed Physician who is employed by or contracts with the Third Party Administrator to provide services including, but not limited to, Preauthorization, utilization management and quality assurance reviews.

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

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

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

If the Plan provides dental benefits (defined), then "Medically Necessary" shall include the word, "dental" when the word "medical" is used and "dentally" when the word "medically" is used when context clearly indicates such applicability.

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

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

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

**Mid-Level Provider** means a healthcare professional, other than a Physician, who provides patient care within the scope of their license and the requirements and limitations of applicable law. Examples of Mid-Level Providers include but are not limited to physician assistants and advance practice registered nurses.

**Network** means the "Carle Health & Affiliated Providers Network" and the "Health Alliance Network", which are defined as follows:

- **Carle Health & Affiliated Providers Network** means the local network of Carle-affiliated Providers, Carle Richland Memorial Hospital Providers, Carle BroMenn Medical Center Providers, Carle Eureka Hospital Providers and FirstHealth of the Carolinas Providers that Covered Persons may access. A Covered Person who resides *within* 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, is required to use the Carle Health & Affiliated Providers Network.

- **Health Alliance Network** means the following:
    - For Covered Persons who reside *within* 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, the Health Alliance Network includes Health Alliance-contracted Providers (including for example: through December 31, 2022: PHCS/MultiPlan Providers; effective January 1, 2023: First Health Network Providers) and is part of the Extended Network which requires

Preauthorization **in advance** of receiving services. Christie Clinic and OSF Heart of Mary Medical Center and OSF Sacred Heart Medical Center are specifically excluded from the Health Alliance Network. Also not included in the Health Alliance Network is the Carle Health & Affiliated Providers Network due to its Preferred Provider status.

- For Covered Persons who reside *outside* 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, the Carle Health & Affiliated Providers Network and Health Alliance-contracted Providers (including for example: through December 31, 2022: PHCS/MultiPlan; effective January 1, 2023: First Health Network Providers), Signal Health Network Providers and Confluence Health Network Providers). Christie Clinic and OSF Heart of Mary Medical Center and OSF Sacred Heart Medical Center are specifically excluded from the Health Alliance Network. Covered Persons may access the Health Alliance Network *without* a Preauthorization requirement.

To determine if a Physician or Provider is a Carle Health & Affiliated Providers Network Provider or Health Alliance Network Provider, Covered Persons may log onto the Third Party Administrator's website as a member to view the Plan's Network Provider Directory(ies) or contact the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. NOTE that the terminology used on the website may not mirror the terminology used in the Plan.

**Non-Preferred Provider** means:

- a Physician or Provider who has not entered into a valid contract to provide health care services to Covered Persons; or
- an Extended Network Provider, when a Covered Person has not obtained Preauthorization to use the Extended Network Provider.

*A Non-Preferred Provider is not responsible for obtaining required Preauthorization on a Covered Person's behalf. The Covered Person is responsible for ensuring that required Preauthorization is completed **in advance** of incurring expenses for use of Providers or treatment/services that require Preauthorization.*

**Open Enrollment** means a period of time determined by the Plan Administrator during which certain eligible persons may modify their enrollment choices.

**Out-of-Pocket Maximum** means the maximum dollar amount a Covered Person will pay in accumulated Copayments, Coinsurance and Deductible amounts for most health care services during a Benefit Period. See also the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS, BENEFIT PERIOD OUT-OF-POCKET MAXIMUMS" section.

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

**Outpatient Surgery** means a surgery or a procedure that is performed in a Physician's office, the Outpatient department of a Hospital, freestanding surgical center or freestanding medical clinic. Charges billed as part of Outpatient Surgery may include the following: surgeon fees, including assistant surgeons, surgical assistants, facility fees and surgical supplies.

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

**Pharmacy** means a licensed establishment where eligible Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

**Physician** means a person licensed to practice medicine in all of its branches under the applicable laws of the state within the United States of America where they practice. A Physician shall include a Mid-Level Provider (see also "Mid-Level Provider" in this "DEFINED TERMS" section).

**Plan** means The Carle Foundation Employees' Health and Dental Plan and any Amendments thereto. The Plan is an employee welfare benefit plan (as defined under ERISA) adopted by the Employer for the benefit of its eligible Employees and Retired Employees, and their eligible Dependents.

**Plan Administrator** means The Carle Foundation.

**Plan ID Card** means a card that is provided to each Covered Person upon enrollment in the Plan for identification purposes. Possession of a Plan ID card confers no right to Plan benefits. Replacement cards may be requested by contacting the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID Card.

**Plan Sponsor** means The Carle Foundation.

**Plan Year** means the 12-month period beginning on January 1 and ending December 31 of the same calendar year.

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

**Preferred Provider** means, in addition to a Carle Health & Affiliated Providers Network Provider (see the definition of "Network" above), a Physician or Provider that has entered into a valid contract to provide health care services to Covered Persons.

Expenses incurred when using an Extended Network Provider will be considered at the Preferred Provider benefit level if:

**(1)** the Covered Person resides outside 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374; or

**(2)** the Covered Person resides within 35 miles of the following zip codes: 61801, 61761, 61530, 62450, 60942 or 28374, **and** has obtained Preauthorization to use the Extended Network Provider **in advance** of using the Extended Network Provider.

*An Extended Network Provider is not responsible for obtaining required Preauthorization on a Covered Person's behalf. The Covered Person is responsible for ensuring that required Preauthorization is completed **in advance** of incurring expenses for use of Providers or treatment/services that require Preauthorization.*

To determine if a Physician or Provider is a Preferred Provider, Covered Persons may log onto the Third Party Administrator's website as a member to view the Plan's Network Provider Directory(ies) or contact the Third Party Administrator whose contact information can be found in the "GENERAL PLAN INFORMATION" section. NOTE that the terminology used on the website may not mirror the terminology used in the Plan.

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

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

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

**Provider Directory** means a list of Preferred Providers, Extended Network Providers and Provider networks for the Plan, and the areas they serve.

**Retired Employee (Retiree)** means a former Active Employee of the Employer who was retired while employed by the Employer under the formal, written plan of the Employer and elects to contribute to the Plan the required contribution. A Retired Employee means a qualified, grandfathered Retired Employee who meets the following conditions:

**(1)** A grandfathered early Retiree of the Employer who: (i) was at least age 55 with 25 or more years of service as of January 1, 2006, (ii) retired before turning age 62, and (iii) retired prior to April 1, 2010; **or**

**(2)** A Retired Employee of the Employer who is age 62 or older with 15 years or more of continuous service who retired prior to April 1, 2010; **or**

**(3)** A Retired Employee who was a Physician employed by Carle Holding Group (formerly known as Carle Clinic Association, P.C.) who was age 55 or older with five or more years of continuous service who retired prior to April 1, 2010; **or**

**(4)** A Retired Employee of Carle Holding Group (formerly known as Carle Clinic Association, P.C.) who was age 60 or older with 15 or more years of continuous service who retired prior to April 1, 2010.

An Employee who retired on or after April 1, 2010 is not eligible for coverage under the Plan as a Retired Employee.

**Schedule of Benefits** means the description of benefits available under the Plan that includes but is not limited to Copayments, Coinsurance, Deductibles, Out-of-Pocket Maximums, benefit levels and benefit limitations.

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

**Skilled Nursing Care** means services that can only be performed by or under the supervision of a licensed nurse or a physical, occupational or speech therapist.

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

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

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

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

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

**(5)** It has an effective utilization review plan.

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

**(7)** It is approved and licensed by Medicare.

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

**Specialty Prescription Drug** means a Prescription Drug or any agent that is obtained from a specialty drug Provider, regardless of dosage form, which requires at least one of the following in order to provide optimal patient outcomes and are identified as a Specialty Prescription Drug by the Plan: (a) specialized procurement handling, distribution or administration in a specialized fashion; (b) complex benefit review to determine coverage; (c) complex medical management; or (d) FDA-mandated or evidence-based, medical-guideline determined, comprehensive patient and/or Physician education.

**Spinal Manipulation** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician or chiropractor to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Spouse** means any individual who is lawfully married to the Employee or Retired Employee under the laws of any domestic or foreign jurisdiction where such individual and Employee or Retired Employee were married. The term "Spouse" does not include domestic partners, partners in a civil union, or partners in a common-law marriage. The Plan Administrator may require documentation proving a legal marital relationship. See also "Domestic Partner" in this "DEFINED TERMS" section.

**Substance Use Disorder** means the uncontrollable and/or excessive abuse of addictive substances that are classified as substance use disorders in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, and the resultant physiological or psychological dependency that develops with continued use and for which treatment is Medically Necessary and appropriate.

**Third Party Administrator** means a person, employer of persons or other entity appointed and authorized by the Plan Administrator to process claims for benefit payments and make determinations on appeals of adverse benefit determinations under the Plan and to provide any other services with respect to the administration of the Plan as the Plan Administrator may request and/or delegate and that the Third Party Administrator agrees to perform. See the "GENERAL PLAN INFORMATION" section for the Third Party Administrator's contact information.

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

**Treatment Plan** means the written, planned program of one or more services or supplies to treat a dental condition.

**Urgent Care** means care for a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect that the absence of medical attention would place the health of the Covered Person in further jeopardy.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994.

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

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

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

The following applies for Plan Years beginning on or after January 1, 2022: See also "Maximum Allowable Charge" and "Usual, Customary and Reasonable Charge" in the "SURPRISE MEDICAL BILLING PROTECTIONS FOR CERTAIN SERVICES—DEFINITIONS FOR PURPOSES OF SURPRISE MEDICAL BILLING PROTECTIONS" section.

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

information.

**Woman's Principal Health Care Provider** means a person licensed to practice medicine in all of its branches under the applicable laws of the state where the where they provide services, specializing in obstetrics and/or gynecology or family practice.

## ADDENDUM: ENHANCED INFERTILITY SERVICES

### ELIGIBLE INFERTILITY SERVICES EXPENSES

**IMPORTANT: Your employer-sponsored group health Plan provides benefits, if determined to be Eligible Expenses, for ENHANCED Infertility services. See the subsection titled "DEFINITIONS FOR PURPOSES OF INFERTILITY SERVICES" for important definitions.**

- Benefits for Infertility services are subject to the Plan's Deductible, Coinsurance and Copayment, as applicable.
- Infertility services, combined, are subject to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.
- Access to Infertility benefits requires approval through the Preauthorization process.

Benefits for Eligible Expenses incurred related to enhanced Infertility services are limited to the following when performed by a Provider:

- Testing and diagnosis of a suspected medical condition;
- Artificial insemination when related to the diagnosis of Infertility;
- Assisted reproductive technology (ART) procedures when related to the diagnosis of Infertility;
- Medications associated with eligible Infertility service expenses are included under the "PRESCRIPTION DRUG BENEFITS" section.

The term "Infertility" means a disease, condition, or status characterized by (1) a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility; (2) a person's inability to reproduce either as a single individual or with a partner without medical intervention; or (3) a licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Benefits for Infertility services include but are not limited to the following when medical criteria has been met. The Health Alliance Medical Policy is used as a guide for determining Medical Necessity.

- **Diagnostic Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.)

  **(1)** Infertility evaluation and subsequent office visits with a Provider, including history and physical examination, for the eligible services listed below as part of the diagnostic work-up;

  **(2)** Laboratory services:

  **(a)** Blood type and Rhesus factor (RH);

  **(b)** Endocrine evaluation/Serum hormonal levels (e.g., gonadotropins: follicle stimulating hormone (FSH) and luteinizing hormone (LH); thyroid stimulating hormone (TSH); cycle day 3 FSH and the clomiphene citrate challenge test (CCCT); androgens (testosterone dehydroepiandrosterone sulfate (DHEA-S)); human chorionic gonadotropin hCG; prolactin; progesterone; estrogens; adrenocortitrophic hormone (ACTH); anti-müllerian hormone (AMH); day 3 inhibin B);

  **(c)** Human immunodeficiency virus (HIV);

  **(d)** Rapid plasma regain (RPR);

  **(e)** Microscopic post-coital cervical mucus examination;

  **(f)** Karyotype testing;

  **(g)** Chlamydia trachomatis screening;

  **(h)** Fasting and two hours post-75 gram glucose challenge levels;

  **(i)** Lipid panel (i.e., total cholesterol; HDL; cholesterol; triglycerides);

**(j)** Cultures (i.e.; chlamydia; gonococcal culture (GC); mycoplasma; urine; semen; prostatic secretion; urological evaluation);

**(k)** Rubella and varicella serology;

**(l)** Hepatitis B and C testing;

**(m)** Semen analysis;

**(n)** Sperm function tests (e.g.; acrosome reaction test; sperm penetration assay);

**(o)** Sperm antibody;

**(p)** Genetic screening;

**(q)** Post-ejaculatory urinalysis; and

**(r)** Sperm-cervical mucus interaction microscopic studies.

**(3)** Imaging:

**(a)** X-ray/Ultrasound (e.g., ovarian; transvaginal; pelvic; transrectal and scrotal);

**(b)** Sonohysterography;

**(c)** Hysterosalpingogram or hystersalpingo-contrast-ultrasonography;

**(d)** CT or MRI of sella turcica (if prolactin is elevated);

**(e)** Vasography; and

**(f)** Venogram.

**(4)** Surgical diagnostic procedures:

**(a)** Hysteroscopy;

**(b)** Endometrial biopsy;

**(c)** Salpingoscopy (falloscopy);

**(d)** Hydrotubation;

**(e)** Laparoscopy and chromotubation;

**(f)** Scrotal exploration; and

**(g)** Testicular biopsy for obstructive azoospermia when gonadotropin levels are normal.

- **Basic Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.)

**(1)** Non-invasive therapies:

**(a)** Pre-conceptual counseling/teaching;

**(b)** Outpatient prescription drugs and specialty prescription drugs for the treatment of Infertility (see also the "PRESCRIPTION DRUG BENEFITS" section of the Plan).

**(2)** Surgical treatment:

**(a)** Laparoscopic or laparotomy treatment of pelvic pathology;

**(b)** Ovarian wedge resection/ovarian drilling/ovarian diathermy;

**(c)** Hysteroscopic adhesiolysis;

**(d)** Tubal ligation (salpingectomy);

**(e)** Hysteroscopic or fluoroscopic cannulation (salpingostomy, finbrioplasty);

**(f)** Tubal reconstruction (unilateral or bilateral tuboplasty and tubal anastomosis);

**(g)** Varicocelectomy (ligation);

**(h)** Microscopic epididymal sperm aspiration;

**(i)** Surgical correction of epididymal blockage;

**(j)** Spermatocelectomy and hydrocelectomy;

**(k)** Transurethral resection of ejaculatory ducts (TURED); and

**(l)** Orchipexy.

**(3)** Artificial insemination (AI), intracervical, intrauterine (IUI) or fallopian tube sperm perfusion (FSP).

- **Enhanced Infertility services:** (**IMPORTANT:** Benefits for all Infertility services are available up to the benefit limitations, if any, as specified in the "SCHEDULE OF BENEFITS—MEDICAL AND PRESCRIPTION DRUG BENEFITS" section.)

**(1)** Assisted reproductive technology (ART) procedures:

**(a)** In vitro fertilization (IVF) (e.g., gamete intrafallopian tube transfer (GIFT); zygote intrafallopian tube transfer (ZIFT); intracytoplasmic sperm injection (ICSI)) (See also the subsection "EXCLUDED INFERTILITY SERVICES EXPENSES" below);

**(b)** Uterine embryo lavage;

**(c)** Embryo transfer;

**(d)** Low tubal ovum transfer;

**(e)** Transfer procedures;

**(f)** Donor sperm and eggs medical costs;

**(i)** Considered an Eligible Expense if Covered Person meets criteria to be eligible for the procedure. Covered Persons using known or unknown donors are required to use an in-network Provider, if available, for the collection, processing and billing of the donor sperm and/or eggs. This includes Covered Persons with out-of-network benefits;

**(ii)** Oocyte donation;

**(iii)** Donor insemination;

**(iv)** Sperm retrieval techniques to overcome anejaculation;

**(v)** Assisted hatching for the following:

**1.** Zona pellucida thickening; or

**2.** Embryo deficits.

**(g)** Oocyte retrievals.

See below for services that are considered excluded expenses under the Plan.

## EXCLUDED INFERTILITY SERVICES EXPENSES

The following Infertility services are excluded under the Plan:

**(1)** All expenses for surrogate/gestational carrier maternity care for purposes of childbirth (unless the Plan provides benefits for a surrogate who is a Covered Person under the Plan).

**(2)** Cryopreservation and storage of sperm, eggs and embryos.

**(3)** Non-medical fees, such as donor fees.

**(4)** Travel costs associated with Infertility treatment.

**(5)** Donor embryos.

**(6)** Selective termination of an embryo.

**(7)** Drugs associated with excluded Infertility services.

**(8)** Reversal of a voluntary sterilization.

**(9)** GIFT and ZIFT are not considered Eligible Expenses for female Covered Persons whose male partner has severe male factor Infertility or unexplained Infertility because there is insufficient evidence to recommend either procedure over IVF for these indications.

**(10)** Experimental or investigational treatments, and procedures performed for research purposes.

**(11)** Preimplantation genetic screening (PGS).

**(12)** Infertility services are not considered Eligible Expenses if either partner has had a reversal of a voluntary sterilization.

**(13)** Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

**(14)** Fertility drugs associated with eligible Infertility services are not considered Eligible Expenses for retired employees and their dependents.

## DEFINITIONS FOR PURPOSES OF INFERTILITY SERVICES

"**Covered Person**" means an employee or dependent, as defined in the Plan, who is enrolled in the Plan. In certain situations, a "Covered Person" also means a former employee or former dependent who is enrolled in the Plan.

"**Eligible Expense(s)**" mean(s) the expenses incurred services, supplies and/or treatment if determined to be Medical Necessary and appropriate, subject to all Plan provisions, limitations and requirements.

"**Health Alliance Medical Policy**" means a medical policy developed by Health Alliance for determining Medical Necessity. It is available for use by the Plan Administrator and its designee to assist with the administration of benefits under the Plan, including but not limited to, determinations of Medical Necessity. The Health Alliance Medical Policy provides the criteria that must be met before benefits are provided for certain healthcare services under the Plan. The Health Alliance Medical Policy does not replace or amend the Plan requirements, or in any way affect the discretionary authority of the Plan Administrator.

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

All of the above criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary and appropriate. The Plan Administrator or its designee has the discretionary authority to decide if care or treatment is Medically Necessary and appropriate.

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

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

"**Plan**" means The Carle Foundation Employees' Health and Dental Plan, which is the written document used to communicate benefit provisions, limitations, rights, and obligations to persons enrolled in the Plan provided by the Plan Sponsor.

"**Plan Sponsor**" means The Carle Foundation.

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

"**Pregnancy**" means childbirth and conditions associated with pregnancy, including complications.

## ADDENDUM: ENHANCED INFERTILITY SERVICES

"**Provider**" means an individual or organization licensed to provide healthcare services under the applicable laws of the state within the United States of America where they provide services.

*end "ADDENDUM: ENHANCED INFERTILITY SERVICES*

# ADDENDUM: COVID-19

**IMPORTANT PLAN INFORMATION REGARDING COVID-19**

The following information contains important updates to the Plan in response to the public health emergency declared by the U.S. Department of Health and Human Services, the presidentially-declared national emergency related to the 2019 Novel Coronavirus (COVID-19), and matters associated with the global pandemic related to the COVID-19 outbreak.

Please note that some of the benefit enhancements described herein may be temporary due to the Plan Sponsor's intent to provide increased support for Covered Persons during the declared emergency/disaster period.

Due to the rapidly-evolving nature of the public health emergency and regulatory actions being taken in response to that, additional modifications to the Plan may occur. Please watch for updates.

All Plan provisions, limitations and requirements remain intact and applicable unless specifically addressed and communicated to the contrary by the Plan Sponsor, Plan Administrator, or a designee of same.

If you have questions about your specific situation, 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.

## I. MODIFICATION THAT MAY BE REQUIRED DUE TO APPLICABLE LAW

**EFFECTIVE MARCH 1, 2020:**

In the event Plan or benefit modification is required for the Plan to meet minimum requirements of applicable law , the Plan will automatically comply to meet the minimum benefit and associated duration requirements of such applicable law or other regulatory or subregulatory action, whether extended or curtailed. Such requirements will become effective as of the date required by the notice, rule, regulation or other official direction applicable to the Plan.

## II. PREAUTHORIZATION FOR CT OF CHEST

**EFFECTIVE FOR THE DURATION OF THE EMERGENCY RELATED TO COVID-19:**

**Preauthorization requirements for CT of Chest in the case of a suspected COVID-19 diagnosis.** In accordance with the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), the Plan processing procedures are modified to suspend the Plan's standard Preauthorization requirement for CT of Chest in the case of a suspected COVID-19 diagnosis. In the event a Physician does submit a Preauthorization request for CT of Chest with appropriate indicators of a suspected COVID-19 diagnosis, the request will be immediately expedited to "approved" status.

## III. PREAUTHORIZATION FOR IN-HOME OXYGEN THERAPY

**EFFECTIVE AUGUST 27, 2021 THROUGH THE DURATION OF THE EMERGENCY RELATED TO COVID-19:**

**Preauthorization requirements for in-home oxygen therapy in the case of a suspected COVID-19 diagnosis.** The Plan processing procedures are modified to suspend the Plan's standard Preauthorization requirement for in-home oxygen therapy in the case of a suspected COVID-19 diagnosis. In the event a Physician does submit a Preauthorization request for in-home oxygen therapy with appropriate indicators of a suspected COVID-19 diagnosis, the request will be immediately expedited to "approved" status.

The Plan reserves the right to modify or discontinue this temporary benefit without prior notice. 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, to determine benefits.

## IV. DIAGNOSTIC TESTING

### (1) EFFECTIVE MARCH 18, 2020 THROUGH THE DURATION OF THE EMERGENCY RELATED TO COVID-19:

The following is specific to diagnosis of COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits in accordance with the Plan's provisions and limitations, as may be amended.

| TYPE OF MEDICAL EXPENSE | You Pay in-network Providers | You Pay out-of-network Providers |
|---|---|---|
| Testing for COVID-19 | 0% Coinsurance<br>Deductible waived* | 0% Coinsurance<br>Deductible waived* |

**2019 Novel Coronavirus (COVID-19).** Eligible expenses associated with testing for COVID-19 include the following:

**(a)** **Diagnostic Tests.** As provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), the following items are considered eligible expenses for which benefits will be provided at 100 percent. Otherwise-applicable Deductible and/or Copayments and/or Coinsurance requirements will be waived for these expenses. Benefits for the listed services will be provided based on the negotiated rate, if one exists. If no negotiated rate exists, the Plan will base the benefit on the amount of the incurred expense which is based on the cash price publicly posted on the Provider's website, or such other amount as may be negotiated with the Provider.

**(i)** In vitro diagnostic test and testing products for the detection of SARS-CoV-2 or the diagnosis of COVID-19, including serological (antibody) tests for COVID-19 (includes all costs relating to the administration of such in vitro diagnostic products) and tests intended for at-home COVID-19 testing (including tests where the individual performs self-collection of a specimen at home) when the test is ordered by a Provider, which satisfy one of the following conditions:

**(A)** is approved, cleared, or authorized by the Food and Drug Administration (FDA) (including an emergency use authorization);

**(B)** the developer has requested or intends to request emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

**(C)** is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or

**(D)** items deemed appropriate by the Secretary of Health and Human Services or as otherwise provided by applicable regulation or related guidance.

**(ii)** Items and services furnished to a Covered Person during in and/or out of network health care Provider office visits (including in-person visits and telehealth visits*), urgent care center visits, or emergency room visits that result in an order for or administration of an in vitro diagnostic test or testing

product described above. Such items and services must relate to the furnishing or administration of such diagnostic test or product or to the evaluation of the individual for purposes of determining the need for such test or product.

* **NOTE:** IRS requirement for Plan Years beginning on or after January 1, 2022: High deductible health plans (HDHP) paired with Health Savings Accounts (HSA) are not permitted to waive the deductible for telehealth services, except when telehealth is part of preventive care services. Non-preventive care telehealth services are subject to the appropriate deductibles, coinsurance and copayments specified in the "SCHEDULE OF BENEFITS" section.

**(2) MEDICALLY NECESSARY AND PROVIDER-DIRECTED COVID-19 TESTS**

**(a) EFFECTIVE AUGUST 1, 2020:**

If Medically Necessary and Provider-directed, or authorized through the Carle COVID Hotline, a COVID-19 test is considered at no cost-sharing to the Covered Person if a referring Provider is named on the claim. If the referring Provider is not named on the claim, expenses incurred will be subject to the diagnostic testing Deductibles and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

**(3) COVID-19 TESTING REQUIRED AS PART OF PRE-PROCEDURE TESTING:**

**(a) EFFECTIVE AUGUST 1, 2020 THROUGH MARCH 4, 2021:**

When COVID-19 testing is required as part of pre-procedure testing:

- Preferred process: COVID-19 testing is performed at a Carle Health & Affiliated Providers Network Provider. The Covered Person is responsible for a portion of the costs to the same extent as required for any other pre-procedure testing.
- Alternate process: The Covered Person may elect to go to a free testing center to have the COVID-19 test and provide the results to the Provider who required the test.

**(b) EFFECTIVE MARCH 5, 2021:**

When COVID-19 testing is required as part of pre-procedure testing:

- Preferred process: COVID-19 testing is performed at a Carle Health & Affiliated Providers Network Provider. Expenses incurred will be provided at 100 percent. Otherwise applicable Deductible and/or Copayments and/or Coinsurance requirements will be waived for these expenses.
- Alternate process: The Covered Person may elect to go to a free testing center to have the COVID-19 test and provide the results to the Provider who required the test.

**(4) COVID-19 TESTING FOR PUBLIC HEALTH SURVEILLANCE AND EMPLOYMENT PURPOSES**

**(a) EFFECTIVE AUGUST 1, 2020 THROUGH SEPTEMBER 30, 2021:**

| TYPE OF MEDICAL EXPENSE | You Pay in-network Providers | You Pay out-of-network Providers |
|---|---|---|
| COVID-19 Testing for Public Health Surveillance and Employment Purposes | 0% Coinsurance<br>Deductible waived | 0% Coinsurance<br>Deductible waived |

Expenses incurred for COVID testing conducted to screen for general workplace health and safety (such as employee return to work testing and for unvaccinated employees) are considered eligible expenses for which benefits will be provided at 100 percent. Otherwise applicable Deductible and/or Copayments and/or Coinsurance requirements will be waived for these expenses.

**(b) EFFECTIVE OCTOBER 1, 2021:**

| TYPE OF MEDICAL EXPENSE | You Pay in-network Providers | You Pay out-of-network Providers |
|---|---|---|
| COVID-19 Testing for Public Health Surveillance and Employment Purposes | 20% Coinsurance after Deductible | 50% Coinsurance after Deductible |

Expenses incurred for COVID testing conducted to screen for general workplace health and safety (such as employee return to work testing and for unvaccinated employees) are considered eligible expenses and subject to the Plan's diagnostic testing Deductible and Coinsurance amounts specified in the "SCHEDULE OF BENEFITS" section.

**(5) COVID OVER-THE-COUNTER (OTC) TESTS**

**EFFECTIVE JANUARY 15, 2022 THROUGH THE DURATION OF THE EMERGENCY RELATED TO COVID-19:**

**2019 Novel Coronavirus (COVID-19).** Eligible expenses associated with testing for COVID-19 include the following:

**(a)** **COVID-19 Over-the-Counter Tests (OTC Tests).** The Plan will consider OTC Tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19 as eligible expenses which satisfy any <u>one</u> of the following:

**(i)** Is approved, cleared, or authorized by the Food and Drug Administration (FDA) (including an emergency use authorization);

**(ii)** The developer has requested or intends to request emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

**(iii)** Is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or

**(iv)** Items that are deemed appropriate by the Secretary of Health and Human Services.

OTC Tests do not require Preauthorization or involve an individualized clinical assessment from a Provider. **OTC Tests are limited to eight (8) tests per Covered Person per month.** This quantity limitation does not apply if the OTC Test is acquired with the involvement of an individualized clinical assessment or a prescription by a Provider.

- **Purchase of OTC Tests at "specific in-network Pharmacies":** A "specific in-network Pharmacy" is one for which the Plan has made arrangements to be considered in-network specifically for the purchase of OTC Tests. To obtain an OTC Test at no cost share, a "specific in-network Pharmacy" must be used. Such Pharmacies may or may not include Pharmacies that are in-network for standard prescription drug benefits under the Plan. For a list of "specific in-

network Pharmacies", contact the Pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section, or customer service at the phone number on the Plan ID/Rx Card.

When purchasing OTC Tests at "specific-in-network Pharmacies", the Covered Person must present their Plan ID/Rx Card ***at the pharmacy counter***. *Doing so will allow the Covered Person to purchase the test(s) at zero cost share.*

Expenses incurred for OTC Tests that are not purchased at the Pharmacy counter with the Plan ID/Rx Card are not eligible for zero cost share.

- **Purchase of OTC Tests at a Pharmacy or retail site other than at a Pharmacy counter of a specific in-network Pharmacy:** Covered Persons can request reimbursement by completing the reimbursement form which can be found at: https://covidtest.optumrx.com/covid-test-reimbursement. Proof of purchase documentation (e.g., copy of purchase receipt and copy of UPC code from the packaging) is required to be submitted with the completed reimbursement form. For questions, contact the Pharmacy benefit manager whose contact information can be found in the "GENERAL PLAN INFORMATION" section or on the Plan ID/Rx Card.

The following limitations apply:

**(A)** No benefits are available if reasonable evidence exists that the purchase was solely for employment purposes; and

**(B)** No benefits are available if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than a Covered Person. **NOTE:** The Plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under the FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test.

## V. QUALIFYING PREVENTIVE SERVICES

**EFFECTIVE MARCH 18, 2020:**

**Qualifying Coronavirus Preventive Services**. The following items are considered eligible expenses for which benefits will be provided at 100 percent. Otherwise-applicable deductible and/or copayments and/or coinsurance requirements will be waived for these expenses. Preauthorization is not required.

**(1)** An item, service, or immunization that has in effect a grade of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and

**(2)** An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

**(3)** Benefits include items and services that are integral to the furnishing of recommended preventive services, including the administration of COVID-19 immunizations.

As new qualifying Coronavirus preventive items, services, and immunizations become available, each will be considered eligible for applicable benefits no later than 15 business days after the qualifying recommendation (USPSTF, ACIP or other federally-required qualifying criteria).

## VI. EXTENSIONS OF TIMEFRAMES AFFECTING THE RIGHTS OF PLAN PARTICIPANTS

**COVID-19 Relief: Extensions of Timeframes Affecting the Rights of Plan Participants.** As part of an effort to minimize the possibility of individuals losing benefits due to a failure to meet specific Plan timelines and health plans failing to meet timelines for providing certain notices, the Plan provides benefits consistent with requirements of the federal government's "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak" (29 CFR Parts 2560 and 2590) in conjunction with the Disaster Relief Notice 2020-01*****, **as clarified by EBSA Disaster Relief Notice 2021-01 issued February 26, 2021.** The relief period under these requirements began March 1, 2020.

Individuals and plans with timeframes that are subject to the relief under the requirements will have the applicable periods under the requirements disregarded *until the earlier of*:

**(a)** one year from the date they were first eligible for relief, or

**(b)** 60 days after the announced end of the National Emergency (the end of the outbreak period).

On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under the requirements will resume.

These requirements provide temporary relief in the form of extensions of Plan timeframes (items 1 through 8) listed below.

**(1)** 30-day (or 60-day) period to request special enrollment under ERISA section 701(f) and Code section 9801(f).

**(2)** The date within which individuals may file a benefit claim.

**(3)** The date within which an individual may appeal an adverse benefit determination.

**(4)** The date within which an individual may file information to perfect a request for external review.

**(5)** 60-day election period for COBRA continuation coverage.

**(6)** The date for making COBRA premium payments.

**(7)** The date to notify the plan of a qualifying event or determination of disability.

**(8)** Determining the date for providing a COBRA election notice.

For assistance with information pertaining to your situation relating to items (1), (2), (3), and (4) above, contact Health Alliance customer service at the phone number on your Plan ID Card. For matters involving COBRA continuation, please contact the plan sponsor, plan administrator or COBRA administrator for assistance.

***** Jointly-issued by the Department of Labor Employee Benefits Security Administration, Internal Revenue Service, and Department of Treasury.

## VII. EARLY PRESCRIPTION REFILL ALLOWANCE

**EFFECTIVE THROUGH THE DURATION OF THE EMERGENCY RELATED TO COVID-19:**

**Prescription Drug Supplies: Early Refill (a.k.a. "Refill-Too-Soon") Allowance.** To support a Covered Person's ability to maintain at least a 30-day supply of Prescription Drugs, the Plan will permit

refills to be provided in advance of the scheduled refill date on the condition that the prescription remains valid beyond the refill date. The early refill allowance does not apply to specialty medications; it does not apply when the patient already has 30 or more days of medicine remaining, and it does not apply to Prescription Drugs with a high likelihood of abuse, including but not limited to opioids.

## ADDENDUM: BE HEALTHY—PREVENTIVE SERVICE BENEFITS

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

CarleHealth

Be Healthy

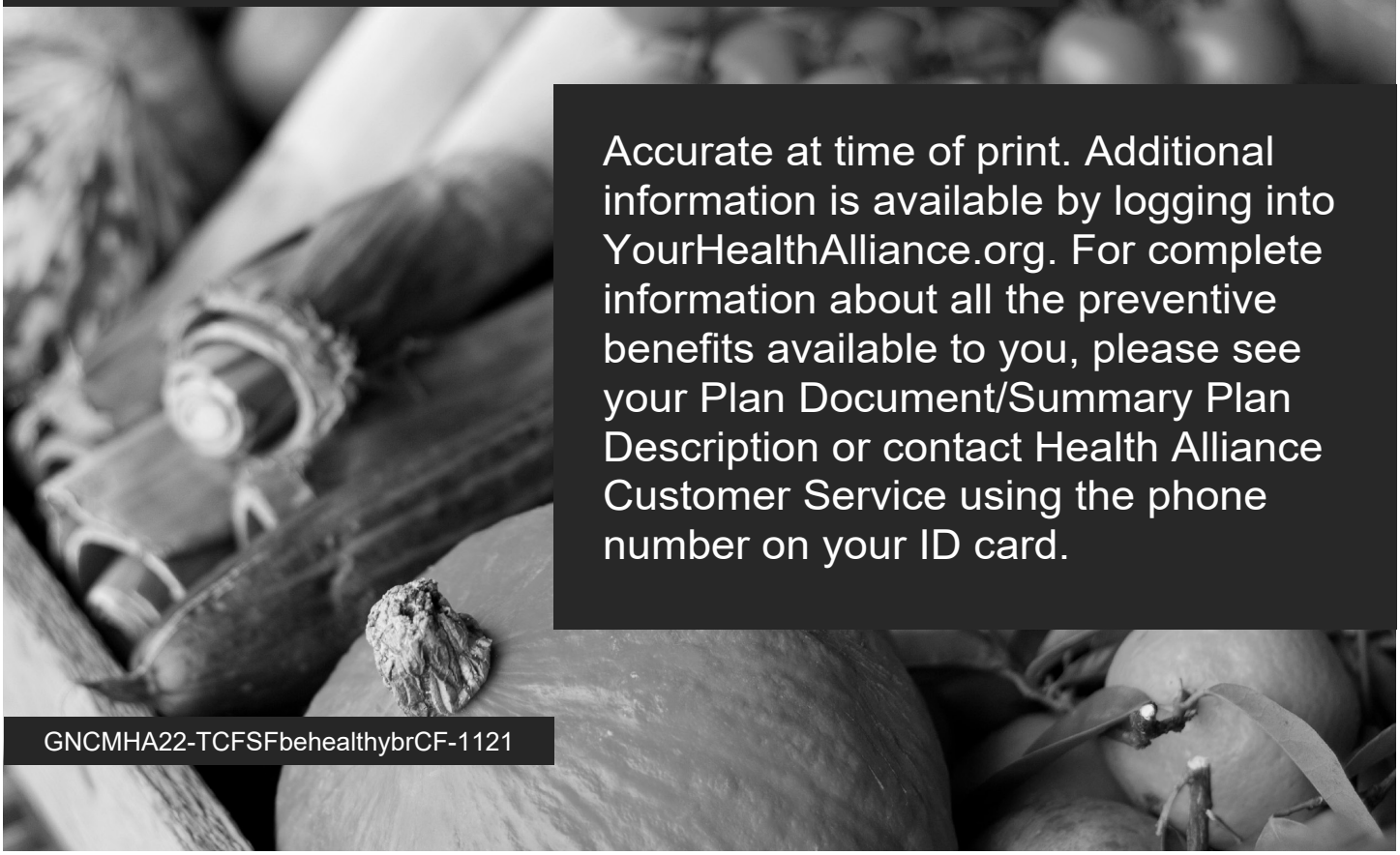
Preventive Service Benefits
The Carle Foundation
Self-Funded Plans

# 2022
# Be Healthy
## Preventive service benefits made for you.

Effective Date: 1/1/2022

## Your health matters most.

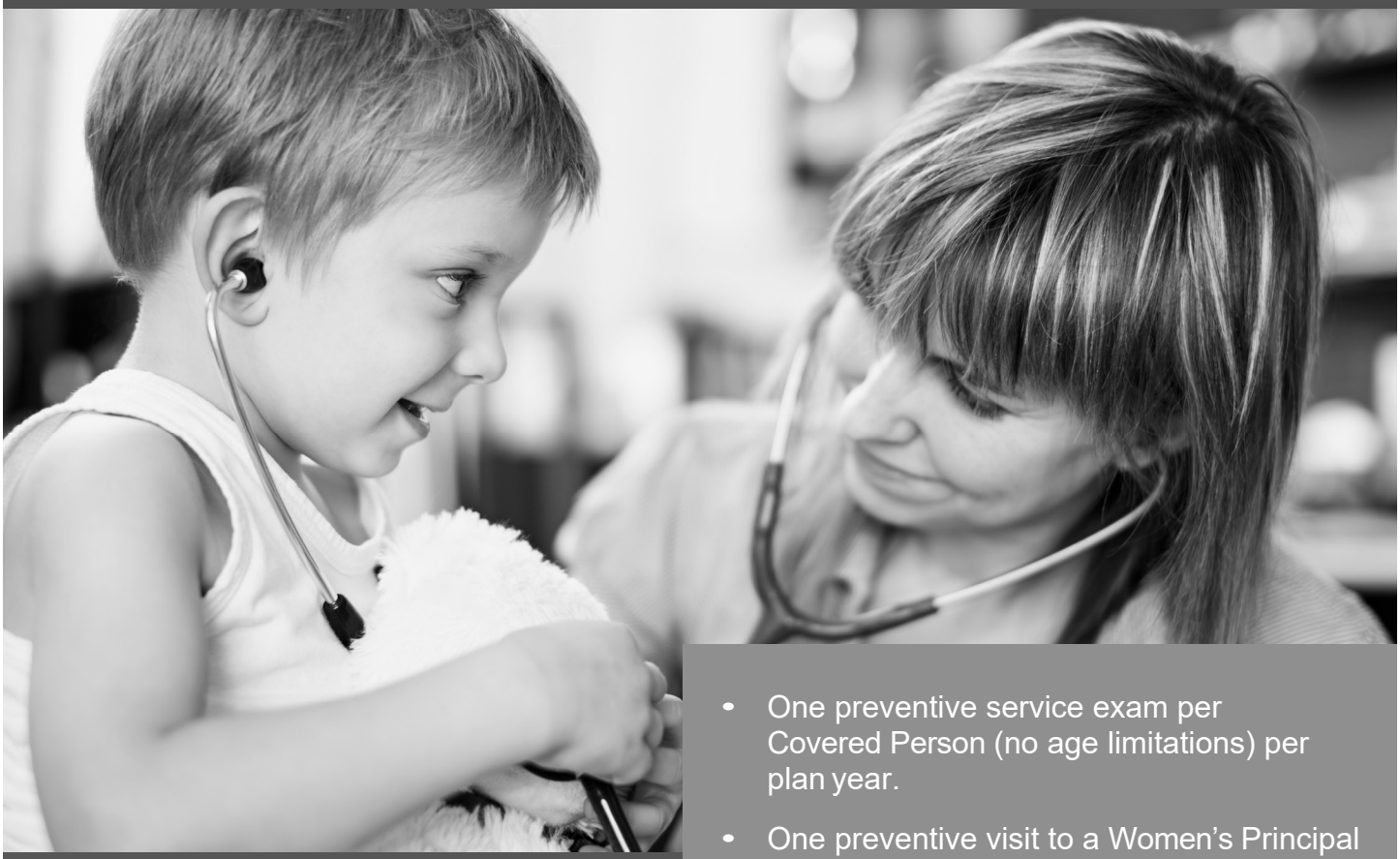
You deserve support all the time, not just when you're sick. That's why your plan offers comprehensive preventive service coverage.



Accurate at time of print. Additional information is available by logging into YourHealthAlliance.org. For complete information about all the preventive benefits available to you, please see your Plan Document/Summary Plan Description or contact Health Alliance Customer Service using the phone number on your ID card.

GNCMHA22-TCFSFbehealthybrCF-1121

Your plan covers preventive services and tests to keep you 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.
- One preventive visit to a Women's Principal Healthcare Provider per plan year.
- 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).

*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 ages |
| 90647–90648 | Hib |
| 90649<br>90650–90651 | HPV quadrivalent 3 dose ages 9–26<br>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 |
| 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**<br>**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<br><br>Requires health plan prior authorization |
| G0328, 82270, 82274 | Fecal immunochemical test (FIT) and Fecal Occult Blood Tests (FOBT), including immunoassay | 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 | Once per year 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.<br><br>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.<br>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.<br><br>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.<br><br>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<br>With diagnosis code Z00.121–Z00.129 |

| | | |
|---|---|---|
| 83655 | Lead screening | Age 0-6 years for children who are at risk for exposure<br>With diagnosis code Z00.121–Z00.129 |
| 80061, 82465, 83721, 84478 | Dyslipidemia screening | Age 21 and younger<br>With diagnosis code Z00.121–Z00.129, Z13.220 |
| S3620 | Newborn metabolic screening panel | |
| **Sexually Transmitted Disease** | | |
| 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<br>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 | Breast pump, manual | |
| **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 | |
| S4989, J7296–J7298, J7301 | Contraceptive intrauterine device (IUD), including implants and supplies | |
| J7307 | Contraceptive non-biodegradable drug implant and supplies | |
| J1050, 96372 | Medroxyprogesterone acetate and administration | |

| | | |
|---|---|---|
| 11982, 11983 | Insertion and removal of non-biodegradable implant | |
| 57170 | Diaphragm or cervical cap fitting with instructions | |
| 58300, 58301 | Insertion and removal of intrauterine device (IUD) | |
| 58565 | Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants | |
| 58600, 58605, 58611 | Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral | |
| 58615 | Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach | |
| 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transaction) | |
| 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip or Falope ring) | |
| **Women's Health – Breast Cancer Screening** | | |
| 77067, 77063 | Screening mammography | Once a 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 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.**

## 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 851-3379 (800)، ولاية واشنطن: اتصل بالرقم: 750-3515 (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).

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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).