

PLAN DOCUMENT

PARK DISTRICT RISK MANAGEMENT AGENCY

HEALTH PROGRAM

Effective January 1, 2026

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I. IMPORTANT PHONE NUMBERS/CONTACT INFORMATION

FOR	CALL
<p>PPO Medical Claims Processor Questions about coverage, claim status, claim calculations, claim reconsideration and access to Benefits Value Advisors for additional plan support and resources.</p>	<p>Blue Cross and Blue Shield of Illinois 800-772-6895 www.bcbsil.com 24 hours a day, 7 days a week, excluding major U.S. holidays</p>
<p>Vision Claims Processor Questions about coverage, claim status or network providers.</p>	<p>Davis Vision 800-999-5431 7:00 a.m. – 10:00 p.m. Monday – Friday 8:00 a.m. – 3:00 p.m. Saturday 11:00 a.m. – 3:00 p.m. Sunday</p>
<p>PPO Medical Care Management Organization To pre-authorize medical treatment.</p>	<p>Blue Cross and Blue Shield of Illinois Utilization Management 800-635-1928 8:00 a.m. – 6:00 p.m. Monday - Friday 9:00 a.m. – 1:00 p.m. Saturday and Sunday</p>
<p>AccessHope Cancer Support Team Tools, resources and expertise to help you before, during and after cancer treatment.</p>	<p>AccessHope 800-772-6895 – ask for a cancer care nurse 8:00 a.m. – 8:00 p.m. Monday - Friday</p>
<p>PPO Mental Health and Substance Abuse Care Management Organization To pre-authorize mental health or substance abuse treatment.</p>	<p>Blue Cross and Blue Shield of Illinois Utilization Management 800-851-7498 8:00 a.m. – 6:00 p.m. Monday - Friday</p>
<p>PPO Maternity Management Expectant mothers with a high risk pregnancy are encouraged to call customer service to be connected with maternity management case worker.</p>	<p>High-risk Maternity Management 800-772-6895 8:00 a.m. – 6:00 p.m. Monday - Friday</p>

FOR	CALL
<p>PPO Pharmacy Benefit Manager Questions about the pharmacy prescription benefit, how to submit mail order prescriptions, or questions about a current mail order prescription. Do not use this card for Workers Compensation related prescriptions. For Workers Compensation call the PDRMA Claims Department at 630-769-0332 for authorization.</p>	<p>CVS Caremark 1-844-211-4271 www.caremark.com 24 hours per day 7 days per week Group number: PDRMA</p>
<p>PPO Prescription Services To start a new Mail Order prescription over the phone or for any mail order questions.</p>	<p>CVS Caremark 1-888-208-9634 24 hours a day, 7 days a week</p>
<p>PPO Specialty Pharmacy To fill a prescription for a drug that is injectable and infused, high cost, or requires special delivery or refrigeration.</p>	<p>CVS Caremark 1-800-237-2767 24 hours a day, 7 days a week</p>
<p>Teladoc Consult with board certified physicians, dermatologists, licensed therapists, psychiatrists, and psychologists via telephone or online video conference.</p>	<p>Teladoc 1-800-835-2362 www.teladoc.com/bcbsil 24 hours a day, 7 days a week</p>
<p>Hearing Aid Coverage Participants must call for a referral to an EPIC Hearing Healthcare provider to access coverage for hearing aids and hearing exams.</p>	<p>EPIC Hearing Healthcare 1-866-956-5400 www.epichearing.com 8:00 a.m. to 8:00 p.m. Monday through Friday</p>
<p>Dental Dental benefits are addressed in a separate booklet.</p>	<p>Delta Dental 1-800-323-1743 www.deltadentalil.com 7:00 a.m. to 7:00 p.m. Monday through Wednesday and 7:00 a.m. to 5:00 p.m. Thursday and Friday</p>

FOR	CALL
<p>Employee Assistance Program (EAP) Short-term counseling, coaching, crisis support, referrals, and legal and financial consultations.</p>	<p>Ulliance 1-800-448-8326 www.lifeadvisor.com ALL CALLS ARE CONFIDENTIAL 24 hours a day, 7 days a week</p>
<p>Questions about COBRA (Consolidated Omnibus Budget Reconciliation Act) or Uniformed Services Employment and Reemployment Rights Act (USERRA) or questions about health benefits upon retirement.</p>	<p>PlanSource COBRAPoint 888-266-1732 9:00 a.m. to 10:00 p.m. Monday - Friday</p> <p>OR</p> <p>PDRMA Health Program 1-630-435-8998 8:00 a.m. to 4:30 p.m. Monday – Friday Out of area callers may contact PDRMA toll free at 1-877-PDRMA01.</p>

All times listed are based on Central Standard Time (CST).

II. INTRODUCTION

This Plan Document becomes effective as of January 1, 2026.

WHEREAS, the Park District Risk Management Agency (PDRMA) Health Program has established a cooperative to provide benefit programs for its members, and whereas the members desire to establish a Plan to maintain medical, vision and employee assistance program benefits for their Employees who are beneficiaries of the Plan, they therefore create and establish the Park District Risk Management Agency Health Program Benefit Plan, hereinafter referred to as the "Plan" and this document thereafter referred to as the "Plan Document." The PDRMA Health Program also administers a dental benefit; plan design information is addressed in a separate booklet.

The PDRMA Health Program administers the Plan and hereinafter will be referred to as the "Plan Administrator".

Purpose

The purpose of this Plan Document is to set forth the provisions of the Plan, which provide for the payment or reimbursement of all or a portion of covered medical and vision expenses, as well as an Employee Assistance Program ("EAP").

Benefits of this Plan shall be payable for expenses incurred on the effective date of this Plan Document, and after, except as specified.

PDRMA reserves the right to revise the Plan of benefits, the eligibility provisions and any other provisions stated herein as necessary and to make any and all determinations under the Plan, including:

- who is eligible for benefits
- the amounts of benefits payable, if any
- the meaning and applicability of Plan provisions, and any such determinations shall be conclusive and binding upon all parties having dealings with the Plan.

This Plan Document shall be the primary governing document used in determining medical, vision, hearing, and EAP benefits to which members are eligible and may be amended from time to time by the PDRMA Health Program Council to reflect changes in benefits or eligibility requirements. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation. Any change so made shall be binding on each individual covered and on any other individual or individuals referred to in this Plan Document.

III. SUMMARY OF MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

A. Summary of Limiting Factors

This document serves as the Master Plan Document and as the summary for this Plan. This document describes the conditions under which this Plan will pay for medical care and prescription drugs. There may be circumstances when a Participant and the Participant's medical provider determine that medical care which is not covered by this Plan is appropriate. All decisions regarding medical care are up to a Participant and the Participant's medical provider.

Several factors affect the Participant's receipt of the benefits described in the Schedules of Benefits which follow. The Participant must be properly enrolled and have coverage that is effective. The Participant's benefits are subject to coverage limits, coverage exclusions, claims limitations, satisfaction of Participant cost sharing requirements, and coordination of benefits provisions. Benefits are listed and described first, subject to the limitations described in detail in subsequent sections. Services are as specified; exclusions are examples only.

The level of benefits a Participant receives also depends upon whether a provider is in-network or out-of-network and the "tier" of the provider, as set forth in the Schedules of Benefits below. Some in-network providers are "Tier 1" providers, while other in-network providers are in "Tier 2." The Tier 1 network (also known as the Blue Choice Options PPO network) is basically a subset of the broader PPO network. A Participant does not have to select a primary care provider or choose a provider in advance of when care is needed. A Participant may see a provider in any tier, but the Participant's out-of-pocket expenses generally will be lower for in-network providers as compared to out-of-network providers, with Tier 1 out-of-pocket expenses being the lowest. The reason is that Participant coinsurance is lowest when the Participant sees a Provider in the Tier 1 network, and the deductibles, Participant coinsurance and out-of-pocket maximums are lower for Tier 1 and Tier 2 in-network providers as compared to out-of-network providers. Additionally, as discussed further below, out-of-network providers may "balance bill" patients for the difference between what the Plan pays and the billed amount (whereas in-network providers are not permitted to do so), and may require patients to pay up front. Seeing a Tier 1 in-network provider may save Participants money as compared to seeing a Tier 2 in-network provider, and seeing an in-network provider in either Tiers 1 or 2 will reduce Participant cost as compared to seeing an out-of-network provider.

For a listing of in-network providers and information as to whether an in-network provider is in Tier 1 or Tier 2, refer to the "Provider Finder" at bcbsil.com. If a provider is identified as being in the Blue Choice Options network, that provider is in Tier 1 (under the provider's name it will say "Blue Choice Opt"). If a provider is merely in the larger "PPO Network" (but not Blue Choice Options), that provider is in Tier 2. Out-of-Network Providers are referred to as "Tier 3" Providers.

Note: Some types of providers (primarily ambulance companies and dentists) are "unsolicited" providers, meaning that Blue Cross and Blue Shield of Illinois does not have any such providers in its medical network (neither Tier 1 nor Tier 2), and thus all such providers are out-of-network. In the case

of such unsolicited providers, claims may be paid at the Tier 1 in-network benefit levels based on the Reasonable and Customary Charge.

The benefits to which a Participant is entitled also will depend upon which Benefits Schedule(s) the Employee's Employer makes available to Employees and in which of those options the Participant has enrolled. The different medical benefits schedules are listed in Subsection B below, the prescription drug schedule is listed in Subsection C below, and the different vision schedules are listed in Subsection D below. There may be some drugs that are covered under the medical benefits schedules instead of the prescription drug schedules. To determine which Schedule(s) of Benefits are available to you or which option you selected, please contact your Benefits Coordinator.

Note: All medical benefits are paid at the coinsurance rates set forth in the Schedules below based on the Reasonable and Customary Charge unless otherwise set forth below.

Generally, an out-of-network provider may balance bill Participants above the Reasonable and Customary Charge. The Plan will not pay these amounts, and such charges do not count towards satisfaction of the deductible or out-of-pocket maximum – rather it is the Participant's responsibility to pay these excess amounts. Notwithstanding the preceding, out-of-network providers of Emergency Services, out-of-network air ambulance providers, and certain out-of-network providers performing services at in-network facilities are legally restricted in their ability to balance bill for charges above legally determined amounts. Participants will receive more information as to these restrictions in the explanations of benefits with respect to relevant claims.

B. Schedules of Benefits: Medical

\$250 DEDUCTIBLE PLAN SCHEDULE

\$250 DEDUCTIBLE PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$250 DEDUCTIBLE PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$250	\$250	\$500
Employee + 1 Dependent	\$500	\$500	\$1,000
Employee + 2 or more Dependents	\$750	\$750	\$1,500

The Calendar Year deductible applies to all services unless otherwise indicated.

\$250 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$1,000	\$1,000	\$2,000
Employee + 1 Dependent	\$2,000	\$2,000	\$4,000
Employee + 2 or more Dependents	\$3,000	\$3,000	\$6,000

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$250 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$250 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$250 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists mental health practitioners who treat Mental Health Disorders, and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$250 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived ⁽³⁾	\$30 copay; 100%; deductible waived ⁽³⁾	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

**\$250 DEDUCTIBLE PLAN
BENEFIT PERCENTAGES**

	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms – diagnostic	90%*	85%	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$500 DEDUCTIBLE PLAN SCHEDULE

\$500 DEDUCTIBLE PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$500 DEDUCTIBLE PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN-NETWORK	TIER 2 PPO IN-NETWORK	TIER 3 OUT-OF-NETWORK
Per Individual	\$500	\$500	\$1,000
Employee + 1 Dependent	\$1,000	\$1,000	\$2,000
Employee + 2 or more Dependents	\$1,500	\$1,500	\$3,000

The Calendar Year deductible applies to all services unless otherwise indicated.

\$500 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN-NETWORK	TIER 2 PPO IN-NETWORK	TIER 3 OUT-OF-NETWORK
Employee	\$1,650	\$1,650	\$3,300
Employee + 1 Dependent	\$3,300	\$3,300	\$6,600
Employee + 2 or more Dependents	\$4,950	\$4,950	\$9,900

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; Deductible waived	100%; deductible waived	70%*
Delivery Fee (<i>includes routine prenatal and postnatal Physician care</i>)	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders, and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms - diagnostic	90%*	85%*	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,000 DEDUCTIBLE PLAN SCHEDULE

\$1,000 DEDUCTIBLE PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$1,000 DEDUCTIBLE PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$1,000	\$1,000	\$2,000
Employee + 1 Dependent	\$2,000	\$2,000	\$4,000
Employee + 2 or more Dependents	\$3,000	\$3,000	\$6,000

The Calendar Year deductible applies to all services unless otherwise indicated.

\$1,000 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$2,250	\$2,250	\$4,500
Employee + 1 Dependent	\$4,500	\$4,500	\$9,000
Employee + 2 or more Dependents	\$6,750	\$6,750	\$13,500

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$1,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists mental health practitioners who treat Mental Health Disorders, and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
<i>Physician Office Expenses (includes Second Surgical Opinions)</i>			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived ⁽³⁾	\$30 copay; 100%; deductible waived ⁽³⁾	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
<i>Radiological Imaging and Laboratory Expenses</i>			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

**\$1,000 DEDUCTIBLE PLAN
BENEFIT PERCENTAGES**

	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms – diagnostic	90%*	85%	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,250 DEDUCTIBLE WITH HRA PLAN SCHEDULE

\$1,250 DEDUCTIBLE with HRA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$1,250 DEDUCTIBLE WITH HRA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$1,250	\$1,250	\$1,500
Employee + 1 Dependent	\$2,500	\$2,500	\$3,000
Employee + 2 or more Dependents	\$3,750	\$3,750	\$4,500

The Calendar Year deductible applies to all services unless otherwise indicated.

\$1,250 DEDUCTIBLE PLAN HRA

Your Employer may offer HRA reimbursements as shown below. Check with your Benefits Coordinator to determine if your Employer does so.

*The chart below shows how a portion of the in-network deductible is paid through the HRA and a portion is paid by the Participant. First, the Participant pays a certain amount (the Pre-HRA amount). Then, the HRA pays. **Note:** The HRA may be used to pay for expenses applied to the in-network deductible only; it does not apply to out-of-network expenses.*

\$1,250 Deductible / \$1,000 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$250	\$1,000
Employee +1 Dependent	\$500	\$2,000
Employee +2 or more Dependents	\$750	\$3,000

\$1,250 DEDUCTIBLE WITH HRA PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$2,250	\$2,250	\$3,000
Employee + 1 Dependent	\$4,500	\$4,500	\$6,000
Employee + 2 or more Dependents	\$6,750	\$6,750	\$9,000

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$1,250 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law. If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,250 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,250 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee (<i>includes routine prenatal and postnatal Physician care</i>)	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,250 DEDUCTIBLE PLAN WITH HRA BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

**\$1,250 DEDUCTIBLE WITH HRA PLAN
BENEFIT PERCENTAGES**

**TIER 1
BCO IN-
NETWORK**

**TIER 2
PPO IN-
NETWORK**

**TIER 3
OUT-OF-
NETWORK**

Colonoscopies (*diagnostic, inpatient and Outpatient, all related services*)

90%*; deductible waived

85%*; deductible waived

70%*

Mammograms

Initial mammogram per Calendar Year – routine or diagnostic

100%; deductible waived

100%; deductible waived

100%; deductible waived

Mammograms – routine

100%; deductible waived

100%; deductible waived

100%; deductible waived

Subsequent Mammograms - diagnostic

90%*

85%*

70%*

Preventive Care/Wellness Benefit Expenses ⁽⁵⁾

Office Visit/Exam Only

100%; deductible waived

100%; deductible waived

100%; deductible waived

All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines

100%; deductible waived

100%; deductible waived

100%; deductible waived

Other Physician Ordered Routine Expenses, including laboratory and radiology expenses

100%; deductible waived

100%; deductible waived

100%; deductible waived

Nutritional Counseling

100%; deductible waived

100%; deductible waived

100%; deductible waived

Hearing Aids

100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived

100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived

No coverage

All Other Covered Expenses

90%*

85%*

70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE PLAN SCHEDULE
\$1,500 DEDUCTIBLE PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$1,500 DEDUCTIBLE PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN-NETWORK	TIER 2 PPO IN-NETWORK	TIER 3 OUT-OF-NETWORK
Per Individual	\$1,500	\$1,500	\$3,000
Employee + 1 Dependent	\$3,000	\$3,000	\$6,000
Employee + 2 or more Dependents	\$4,500	\$4,500	\$9,000

The Calendar Year deductible applies to all services unless otherwise indicated.

\$1,500 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN-NETWORK	TIER 2 PPO IN-NETWORK	TIER 3 OUT-OF-NETWORK
Employee	\$2,650	\$2,650	\$5,300
Employee + 1 Dependent	\$5,300	\$5,300	\$10,600
Employee + 2 or more Dependents	\$7,950	\$7,950	\$15,900

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$1,500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms - diagnostic	90%*	85%*	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE WITH HRA PLAN SCHEDULE

\$1,500 DEDUCTIBLE WITH HRA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$1,500 DEDUCTIBLE WITH HRA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$1,500	\$1,500	\$2,000
Employee + 1 Dependent	\$3,000	\$3,000	\$4,000
Employee + 2 or more Dependents	\$4,500	\$4,500	\$6,000

The Calendar Year deductible applies to all services unless otherwise indicated. The in-network deductible may be offset by Employer contributions to a health reimbursement account (“HRA”) on your behalf as set forth under HRA options in this Schedule of Benefits.

\$1,500 DEDUCTIBLE PLAN HRA OPTIONS

Your Employer may offer HRA reimbursements as shown below. Check with your Benefits Coordinator to determine if your Employer does so.

*The chart below shows how a portion of the in-network deductible is paid through the HRA and a portion is paid by the Participant. First, the Participant pays a certain amount (the Pre-HRA amount). Then, the HRA pays. **Note:** The HRA may be used to pay for expenses applied to the in-network deductible only; it does not apply to out-of-network expenses.*

\$1,500 Deductible / \$1,250 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$250	\$1,250
Employee +1 Dependent	\$500	\$2,500
Employee +2 or more Dependents	\$750	\$3,750

\$1,500 Deductible / \$1,000 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$500	\$1,000
Employee +1 Dependent	\$1,000	\$2,000
Employee +2 or more Dependents	\$1,500	\$3,000

\$1,500 DEDUCTIBLE PLAN WITH HRA OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$2,650	\$2,650	\$4,300
Employee + 1 Dependent	\$5,300	\$5,300	\$8,600
Employee + 2 or more Dependents	\$7,950	\$7,950	\$12,900

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$1,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* for a Tier 1 facility, 85%* for a Tier 2 facility ⁽²⁾
Professional provider/Physician services rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined).

An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance (related to an Emergency Medical Condition)	90%*	85%*	90%* (2)
Ambulance Expenses – Ground Transport (related to a Non- Emergency Medical Condition)	90%*	85%*	70%*
Ambulance Services – Air Ambulance by helicopter or airplane (related to a Non-Emergency Medical Condition)	90%*	85%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee (<i>includes routine prenatal and postnatal Physician care</i>)	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year*

\$1,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms – diagnostic	90%*	85%*	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women’s preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE PLAN SCHEDULE

\$2,000 DEDUCTIBLE PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$2,000 DEDUCTIBLE PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$2,000	\$2,000	\$4,000
Employee + 1 Dependent	\$4,000	\$4,000	\$8,000
Employee + 2 or more Dependents	\$6,000	\$6,000	\$12,000

The Calendar Year deductible applies to all services unless otherwise indicated.

\$2,000 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$4,250	\$4,250	\$8,500
Employee + 1 Dependent	\$8,500	\$8,500	\$17,000
Employee + 2 or more Dependents	\$12,750	\$12,750	\$25,500

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$2,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	80%*	75%*	60%*
Outpatient Hospital Expenses	80%*	75%*	60%*
Ambulatory Surgical Center	80%*	75%*	60%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	80%* for a Tier 1 facility, 85%* for a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	60%*

(4) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Participant's 20% coinsurance responsibility will be based on the Recognized Amount (as defined). An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 60% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	60%*
Ambulance Expenses – Air Ambulance (related to an Emergency Medical Condition)	80%*	80%*	80%* (2)
Ambulance Expenses – Ground Transport (related to a Non- Emergency Medical Condition)	80%*	80%*	60%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (related to a Non- Emergency Medical Condition)	80%*	80%*	80%*(2)
Skilled Nursing Facility Expenses	80%*	75%*	60%*
Hospice Care Expenses	80%*	75%*	60%*
Home Health Care Expenses	80%*	75%*	60%*
Private Duty Nursing Expenses	80%*	75%*	60%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	80%*	75%*	60%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	60%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	80%*	75%*	60%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	60%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	60%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	60%*
Allergy and Vitamin Injections	80%*; deductible waived	75%*; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	80%*	75%*	60%*
Outpatient Dialysis	80%*	75%*	60%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	60%*
Preadmission Testing Expenses	80%*	75%*	60%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	80%*	75%*	60%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 80%	100% (deductible waived) up to \$300 per year; then deductible and 75%*	60%*
Durable Medical Equipment Expenses	80%*	75%*	60%*
Orthotic Appliances and Devices	80%*	75%*	60%*
Prosthetic Appliances and Devices	80%*	75%*	60%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	80%*; deductible waived	75%*; deductible waived	60%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms - diagnostic	80%*	75%*	60%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	80%*	75%*	60%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE WITH HRA PLAN SCHEDULE

\$2,000 DEDUCTIBLE WITH HRA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$2,000 DEDUCTIBLE WITH HRA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$2,000	\$2,000	\$2,500
Employee + 1 Dependent	\$4,000	\$4,000	\$5,000
Employee + 2 or more Dependents	\$6,000	\$6,000	\$7,500

The Calendar Year deductible applies to all services unless otherwise indicated. The in-network deductible may be offset by Employer contributions to a health reimbursement account (“HRA”) on your behalf as set forth under HRA Options in this Schedule of Benefits.

\$2,000 DEDUCTIBLE PLAN HRA OPTIONS

Your Employer may offer HRA reimbursements as shown below. Check with your Benefits Coordinator to determine if your Employer does so.

*The chart below shows how a portion of the in-network deductible is paid through the HRA and a portion is paid by the Participant. First, the Participant pays a certain amount (the Pre-HRA amount). Then, the HRA pays. **Note:** The HRA may be used to pay for expenses applied to the in-network deductible only; it does not apply to out-of-network expenses.*

\$2,000 Deductible / \$1,500 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$500	\$1,500
Employee +1 Dependent	\$1,000	\$3,000
Employee +2 or more Dependents	\$1,500	\$4,500

\$2,000 Deductible / \$1,250 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$750	\$1,250
Employee +1 Dependent	\$1,500	\$2,500
Employee +2 or more Dependents	\$2,250	\$3,750

\$2,000 Deductible / \$1,000 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$1,000	\$1,000
Employee +1 Dependent	\$2,000	\$2,000
Employee +2 or more Dependents	\$3,000	\$3,000

\$2,000 DEDUCTIBLE WITH HRA PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$4,250	\$4,250	\$7,000
Employee + 1 Dependent	\$8,500	\$8,500	\$14,000
Employee + 2 or more Dependents	\$12,750	\$12,750	\$21,000

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$2,000 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	80%*	75%*	60%*
Outpatient Hospital Expenses	80%*	75%*	60%*
Ambulatory Surgical Center	80%*	75%*	60%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	80%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	60%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Participant's 20% coinsurance responsibility will be based on the Recognized Amount (as defined). An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 60% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	60%*
Ambulance Expenses Air Ambulance (related to an Emergency Medical Condition)	80%*	80%*	80%*(2)
Ambulance Expenses – Ground Transport (related to a Non- Emergency Medical Condition)	80%*	80%*	60%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (related to a Non-Emergency Medical Condition)	80%*	80%*	80%*(2)
Skilled Nursing Facility Expenses	80%*	75%*	60%*
Hospice Care Expenses	80%*	75%*	60%*
Home Health Care Expenses	80%*	75%*	60%*
Private Duty Nursing Expenses	80%*	75%*	60%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,000 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	80%*	75%*	60%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	60%*
Delivery Fee (<i>includes routine prenatal and postnatal Physician care</i>)	80%*	75%*	60%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	60%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	60%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	60%*
Allergy and Vitamin Injections	80%*; deductible waived	75%*; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,000 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	80%*	75%*	60%*
Outpatient Dialysis	80%*	75%*	60%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	60%*
Preadmission Testing Expenses	80%*	75%*	60%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	80%*	75%*	60%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 80%*	100% (deductible waived) up to \$300 per year; then deductible and 75%*	60%*
Durable Medical Equipment Expenses	80%*	75%*	60%*
Orthotic Appliances and Devices	80%*	75%*	60%*
Prosthetic Appliances and Devices	80%*	75%*	60%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,000 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	80%*; deductible waived	75%*; deductible waived	60%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms – diagnostic	80%*	75%*	60%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	80%*	75%*	60%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,500 DEDUCTIBLE WITH HRA PLAN SCHEDULE

\$2,500 DEDUCTIBLE WITH HRA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$2,500 DEDUCTIBLE WITH HRA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$2,500	\$2,500	\$3,000
Employee + 1 Dependent	\$5,000	\$5,000	\$6,000
Employee + 2 or more Dependents	\$7,500	\$7,500	\$9,000

The Calendar Year deductible applies to all services unless otherwise indicated. The in-network deductible may be offset by Employer contributions to a health reimbursement account (“HRA”) on your behalf as set forth under HRA Options in this Schedule of Benefits.

\$2,500 DEDUCTIBLE PLAN HRA OPTIONS

Your Employer may offer HRA reimbursements as shown below. Check with your Benefits Coordinator to determine if your Employer does so.

*The chart below shows how a portion of the in-network deductible is paid through the HRA and a portion is paid by the Participant. First, the Participant pays a certain amount (the Pre-HRA amount). Then, the HRA pays. **Note:** The HRA may be used to pay for expenses applied to the in-network deductible only; it does not apply to out-of-network expenses.*

\$2,500 Deductible / \$2,000 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$500	\$2,000
Employee +1 Dependent	\$1,000	\$4,000
Employee +2 or More Dependents	\$1,500	\$6,000

\$2,500 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$3,650	\$3,650	\$5,300
Employee + 1 Dependent	\$7,300	\$7,300	\$10,600
Employee + 2 or more Dependents	\$10,950	\$10,950	\$15,900

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$2,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient). ⁽¹⁾	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined). An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, if the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance (related to an Emergency Medical Condition)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (related to a Non- Emergency Medical Condition)	90%*	90%*	70%*
Ambulance Expenses – Air Ambulance (related to a Non-Emergency Medical Condition)	90%*	90%*	90%*
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 85%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms - diagnostic	90%*	85%*	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$3,500 DEDUCTIBLE WITH HRA PLAN SCHEDULE

\$3,500 DEDUCTIBLE WITH HRA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$3,500 DEDUCTIBLE WITH HRA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Per Individual	\$3,500	\$3,500	\$4,000
Employee + 1 Dependent	\$7,000	\$7,000	\$8,000
Employee + 2 or more Dependents	\$10,500	\$10,500	\$12,000

The Calendar Year deductible applies to all services unless otherwise indicated. The in-network deductible may be offset by Employer contributions to a health reimbursement account (“HRA”) on your behalf as set forth under HRA Options in this Schedule of Benefits.

\$3,500 DEDUCTIBLE PLAN HRA OPTIONS

Your Employer may offer HRA reimbursements as shown below. Check with your Benefits Coordinator to determine if your Employer does so.

*The chart below shows how a portion of the in-network deductible is paid through the HRA and a portion is paid by the Participant. First, the Participant pays a certain amount (the Pre-HRA amount). Then, the HRA pays. **Note:** The HRA may be used to pay for expenses applied to the in-network deductible only; it does not apply to out-of-network expenses.*

\$3,500 Deductible / \$3,000 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$500	\$3,000
Employee +1 Dependent	\$1,000	\$6,000
Employee +2 or More Dependents	\$1,500	\$9,000

\$3,500 Deductible / \$3,250 HRA

	Employee Pays Pre-HRA	HRA Reimbursement
Employee	\$250	\$3,250
Employee +1 Dependent	\$500	\$6,500
Employee +2 or More Dependents	\$750	\$9,750

\$3,500 DEDUCTIBLE PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$4,650	\$4,650	\$6,300
Employee + 1 Dependent	\$9,300	\$9,300	\$12,600
Employee + 2 or more Dependents	\$13,950	\$13,950	\$18,900

The out-of-pocket maximum includes the Calendar Year deductible and any copayments other than those applicable to prescription drugs (to which a separate out-of-pocket maximum applies as described below).

\$3,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	90%*	85%*	70%*
Outpatient Hospital Expenses	90%*	85%*	70%*
Ambulatory Surgical Center	90%*	85%*	70%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient. ⁽¹⁾)	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived	\$100 copay; 100%; deductible waived
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	90%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to a Hospital (including a Hospital outpatient department), Ambulatory Surgical Center, and Physician Office) by an out-of-network provider	Not Applicable	Not Applicable	70%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Participant's 10% coinsurance responsibility will be based on the Recognized Amount (as defined). An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to out-of-network billing practices, in compliance with applicable law, If the exception applies, the Plan will pay only 70% of the Reasonable & Customary Charge and the out-of-network deductible and out-of-pocket maximum will apply.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$3,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; deductible waived (1)	\$30 copay; 100%; deductible waived (1)	70%*
Ambulance Expenses – Air Ambulance (related to an Emergency Medical Condition)	90%*	90%*	90%* (2)
Ambulance Expenses – Ground Transport (related to a Non- Emergency Medical Condition)	90%*	85%*	70%*
Ambulance Expenses – Air Ambulance (related to a Non-Emergency Medical Condition)	90%*	90%*	90%*(2)
Skilled Nursing Facility Expenses	90%*	85%*	70%*
Hospice Care Expenses	90%*	85%*	70%*
Home Health Care Expenses	90%*	85%*	70%*
Private Duty Nursing Expenses	90%*	85%*	70%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$3,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	90%*	85%*	70%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	70%*
Delivery Fee (<i>includes routine prenatal and postnatal Physician care</i>)	90%*	85%*	70%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%; deductible waived	\$20 copay ⁽³⁾ ; 100%; deductible waived	70%*
Specialists	\$30 copay ⁽³⁾ ; 100%; deductible waived	\$30 copay ⁽³⁾ ; 100%; deductible waived	70%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%; deductible waived	70%*
Allergy and Vitamin Injections	90%*; deductible waived	85%*; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$3,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (includes Second Surgical Opinions)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	90%*	85%*	70%*
Outpatient Dialysis	90%*	85%*	70%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%; deductible waived (3)	\$30 copay; 100%; deductible waived (3)	70%*
Preadmission Testing Expenses	90%*	85%*	70%*
Radiological Imaging and Laboratory Expenses			
MRI, CT Scan and PET Scan	90%*	85%*	70%*
All services other than MRI, CT Scan and PET Scan	100% (deductible waived) up to \$300 per year; then deductible and 90%*	100% (deductible waived) up to \$300 per year; then deductible and 90%*	70%*
Durable Medical Equipment Expenses	90%*	85%*	70%*
Orthotic Appliances and Devices	90%*	85%*	70%*
Prosthetic Appliances and Devices	90%*	85%*	70%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	70%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$3,500 DEDUCTIBLE WITH HRA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	90%*; deductible waived	85%*; deductible waived	70%*
Mammograms			
Initial mammogram per Calendar Year – routine or diagnostic	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Subsequent Mammograms - diagnostic	90%*	85%*	70%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	100% up to maximum benefit if provided through EPIC Hearing Health Care; deductible waived	No coverage
All Other Covered Expenses	90%*	85%*	70%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 70% out-of-network. (This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required to be covered under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,700 HDHP WITH HSA PLAN SCHEDULE

\$1,700 HDHP WITH HSA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$1,700 HDHP WITH HSA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
For Employee Only Coverage	\$1,700	\$1,700	\$3,400
Employee + 1 Dependent	\$3,400	\$3,400	\$6,800
Employee + 2 or more Dependents	\$3,400	\$3,400	\$6,800

The Calendar Year deductible applies to all services unless otherwise indicated.

\$1,700 HDHP WITH HSA PLAN OUT-OF-POCKET MAXIMUM	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$4,500	\$4,500	\$9,000
Employee + 1 Dependent	\$9,000	\$9,000	\$18,000
Employee + 2 or more Dependents	\$9,000	\$9,000	\$18,000

The out-of-pocket maximum includes the Calendar Year deductible and any copayments (including those applicable to prescription drugs).

\$1,700 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	80%*	75%*	60%*
Outpatient Hospital Expenses	80%*	75%*	60%*
Ambulatory Surgical Center	80%*	75%*	60%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient) ⁽¹⁾	\$100 copay; 80%;	\$100 copay; 80%;	\$100 copay; 80%;
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department) and an Ambulatory Surgical Center by an out-of-network provider	Not Applicable	Not Applicable	80%* if a Tier 1 facility, 85%* if a Tier 2 facility ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to Hospital (including a Hospital outpatient department) and an Ambulatory Surgical Center by and out-of-network provider	Not Applicable	Not Applicable	60%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 20% coinsurance responsibility will be based on the "Recognized Amount" as defined.

An exception applies with respect to certain out-of-network providers who have provided notice to the patients and received informed consent with respect to out-of-network billing practices, in compliance with applicable law. If the exception applies, the Plan will pay only 60% of the Reasonable & Customary Charge.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,700 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100%; (1)	\$30 copay; 100%; (1)	60%*
Ambulance Expenses – Air Ambulance or Ground Transport <i>(related to an Emergency Medical Condition)</i>	80%*	80%*	80%* (2)
Ambulance Expenses – Ground Transport <i>(related to a Non- Emergency Medical Condition)</i>	80%*	75%*	60%*
Ambulance Expenses – Air Ambulance by helicopter or airplane <i>(related to a Non- Emergency Medical Condition)</i>	80%	80%	80%* (2)
Skilled Nursing Facility Expenses	80%*	75%*	60%*
Hospice Care Expenses	80%*	75%*	60%*
Home Health Care Expenses	80%*	75%*	60%*
Private Duty Nursing Expenses	80%*	75%*	60%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount of the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,700 HDHP WITH HSA PLAN BENEFIT PERCENTAGES		IN-NETWORK	OUT-OF- NETWORK
Inpatient Physician Expenses	80%*	75%*	60%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	60%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	80%*	75%*	60%*
Other Pregnancy Related Expenses		Benefits are paid as any other Sickness	
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%	\$20 copay ⁽³⁾ ; 100%	60%*
Specialists	\$30 copay ⁽³⁾ ; 100%	\$30 copay ⁽³⁾ ; 100%	60%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%	60%*
Allergy and Vitamin Injections	80%*	75%*	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$1,700 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	80%*	75%*	60%*
Outpatient Dialysis	80%*	75%*	60%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%	\$30 copay; 100%	60%*
Preadmission Testing Expenses	80%*	75%*	60%*
Radiological Imaging and Laboratory Expenses	80%*	75%*	60%*
Durable Medical Equipment Expenses	80%*	75%*	60%*
Orthotic Appliances and Devices	80%*	75%*	60%*
Prosthetic Appliances and Devices	80%*	75%*	60%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$1,700 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	80%*	75%*	60%*
Mammograms			
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – diagnostic	80%*	75%*	60%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through Epic Hearing Health Care	100% up to maximum benefit if provided through Epic Hearing Health Care	No coverage
All Other Covered Expenses	80%*	75%*	60%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 60% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,500 HDHP WITH HSA PLAN SCHEDULE

\$2,500 HDHP WITH HSA PLAN MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility	100 days per Calendar Year
Hospice Care	Six months in any 3-year period
Home Health Care (<i>all professional visits</i>)	40 visits per Calendar Year
Organ Transplants	
Travel Related Expenses	\$10,000 per transplant; \$200 per day
Hearing Aids	\$1,500 per ear every 5 years with referral. This benefit is offered through EPIC Hearing Healthcare.
Gender Reassignment Surgery	1 Sex Change Lifetime; Participants age 18 and over
Morbid Obesity Surgery	1 procedure Lifetime; Participants age 18 and over

\$2,500 HDHP WITH HSA PLAN CALENDAR YEAR DEDUCTIBLE	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
For Employee Only Coverage	\$2,500	\$2,500	\$5,000
Employee + 1 Dependent	\$5,000	\$5,000	\$10,000
Employee + 2 or more Dependents	\$5,000	\$5,000	\$10,000

The Calendar Year deductible applies to all services unless otherwise indicated.

\$2,500 HDHP WITH HSA PLAN OUT-OF-POCKET MAXIMUM	TIER 2 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Employee	\$5,500	\$5,500	\$11,000
Employee + 1 Dependent	\$11,000	\$11,000	\$22,000
Employee + 2 or more Dependents	\$11,000	\$11,000	\$22,000

The out-of-pocket maximum includes the Calendar Year deductible and any copayments (including those applicable to prescription drugs).

\$2,500 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Hospital Expenses	80%*	75%*	60%*
Outpatient Hospital Expenses	80%*	75%*	60%*
Ambulatory Surgical Center	80%*	75%*	60%*
Emergency Services (including facility, ER Physician and treatments to stabilize a patient) ⁽¹⁾	\$100 copay; 80%	\$100 copay; 75%	\$100 copay; 80%
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an in-network facility (including, but not limited to a Hospital (including a Hospital outpatient department) and an Ambulatory Surgical Center by an out-of-network provider	Not Applicable	Not Applicable	80%* ⁽²⁾
Professional provider/Physician services (other than Emergency Services) rendered with respect to a visit at an out-of-network facility (including, but not limited to Hospital (including a Hospital outpatient department) and an Ambulatory Surgical Center by and out-of-network provider	Not Applicable	Not Applicable	60%*

(1) Benefit includes all related services received in connection with an Emergency Services visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation. With respect to Emergency Services provided by out-of-network providers, the Plan will pay 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums.

The Participant's 20% coinsurance responsibility will be based on the "Recognized Amount" as defined.

An exception applies with respect to certain out-of-network providers who have provided notice to the patients and received informed consent with respect to out-of-network billing practices, in compliance with applicable law. If the exception applies, the Plan will pay only 60% of the Reasonable & Customary Charge.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,500 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Urgent Care Facility Expenses (other than with respect to provision of Emergency Services, which shall be covered as set forth above)	\$30 copay; 100% (1)	\$30 copay; 100% (1)	60%*
Ambulance Expenses – Air Ambulance or Ground Transport (<i>related to an Emergency Medical Condition</i>)	80%*	80%*	80%* (2)
Ambulance Expenses – Ground Transport (<i>related to a Non- Emergency Medical Condition</i>)	80%*	75%*	60%*
Ambulance Expenses – Air Ambulance by helicopter or airplane (<i>related to a Non- Emergency Medical Condition</i>)	80%	80%	80%* (2)
Skilled Nursing Facility Expenses	80%*	75%*	60%*
Hospice Care Expenses	80%*	75%*	60%*
Home Health Care Expenses	80%*	75%*	60%*
Private Duty Nursing Expenses	80%*	75%*	60%*

(1) Benefit includes all related services received in connection with an In-Network provider Urgent Care Facility visit, including but not limited to: radiologist and pathologist, regardless of Network provider affiliation.

(2) Benefits are subject to the In-Network Calendar Year deductible and out-of-pocket maximums. The Plan will pay the lesser of the billed amount of the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,500 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Inpatient Physician Expenses	80%*	75%*	60%*
Pregnancy Related Expenses			
Initial Office Visit	100%; deductible waived	100%; deductible waived	60%*
Delivery Fee <i>(includes routine prenatal and postnatal Physician care)</i>	80%*	75%*	60%*
Other Pregnancy Related Expenses	Benefits are paid as any other Sickness		
Physician Office Expenses <i>(includes Second Surgical Opinions)</i>			
Primary Care Physician (PCP) ⁽⁴⁾	\$20 copay ⁽³⁾ ; 100%	\$20 copay ⁽³⁾ ; 100%	60%*
Specialists	\$30 copay ⁽³⁾ ; 100%	\$30 copay ⁽³⁾ ; 100%	60%*
Therapeutic Injections and Supplies	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%	\$20 PCP copay ⁽³⁾ or \$30 Specialist copay ⁽³⁾ ; 100%	60%*
Allergy and Vitamin Injections	80%*	75%*	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections. Specialty Medications for use during a Physician Office Visit should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

(4) Primary Care Physicians are family practitioners, general practitioners, internists, pediatricians, obstetricians/gynecologists, mental health practitioners who treat Mental Health Disorders and substance abuse practitioners who treat Substance Abuse Disorders. All other practitioners are considered "Specialists" for purposes of this Schedule of Benefits.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

\$2,500 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Physician Office Expenses (<i>includes Second Surgical Opinions</i>)			
Surgery and Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices	80%*	75%*	60%*
Outpatient Dialysis	80%*	75%*	60%*
Acupuncture/Chiropractic Expenses	\$30 copay; 100%;	\$30 copay; 100%;	60%*
Preadmission Testing Expenses	80%*	75%*	60%*
Radiological Imaging and Laboratory Expenses	80%*	75%*	60%*
Durable Medical Equipment Expenses	80%*	75%*	60%*
Orthotic Appliances and Devices	80%*	75%*	60%*
Prosthetic Appliances and Devices	80%*	75%*	60%*
Routine screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 years and continuing until age 75 years and any related services as required under the Affordable Care Act	100%; deductible waived	100%; deductible waived	60%*

(3) Only one copay applies per Physician visit. The copay applies to all expenses except surgery, Durable Medical Equipment, Orthotic Appliances and Devices, Prosthetic Appliances and Devices, and allergy and vitamin injections.

*When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.

\$2,500 HDHP WITH HSA PLAN BENEFIT PERCENTAGES	TIER 1 BCO IN- NETWORK	TIER 2 PPO IN- NETWORK	TIER 3 OUT-OF- NETWORK
Colonoscopies (<i>diagnostic, inpatient and Outpatient, all related services</i>)	80%*	75%*	60%*
Mammograms			
Mammograms – routine	100%; deductible waived	100%; deductible waived	100%; deductible waived
Mammograms – diagnostic	80%*	75%*	60%*
Preventive Care/Wellness Benefit Expenses ⁽⁵⁾			
Office Visit/Exam Only	100%; deductible waived	100%; deductible waived	100%; deductible waived
All immunizations and vaccinations, including Flu Shots and COVID-19 vaccines	100%; deductible waived	100%; deductible waived	100%; deductible waived
Other Physician Ordered Routine Expenses, including laboratory and radiology expenses	100%; deductible waived	100%; deductible waived	100%; deductible waived
Nutritional Counseling	100%; deductible waived	100%; deductible waived	100%; deductible waived
Hearing Aids	100% up to maximum benefit if provided through Epic Hearing Health Care	100% up to maximum benefit if provided through Epic Hearing Health Care	No coverage
All Other Covered Expenses	80%*	75%*	60%*

(5) The Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services in and out-of-network, except colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at 60% out-of-network. This means that these services (other than out-of-network colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. The preventive services to which this rule applies are those that are required under the health care reform law (the Affordable Care Act). To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

**When the out-of-pocket maximum has been reached, further covered expenses are payable at 100% for the remainder of the Calendar Year.*

C. Schedule of Benefits: Prescription Drugs

Please contact the Pharmacy Benefit Manager identified on page 5 for additional information regarding the prescription drug benefits provided under the Plan.

Note that the prescription copays listed below count towards the out-of-pocket maximum for prescription drugs and not to the general out-of-pocket maximum applicable to medical benefits, except with respect to the HDHP with HSA Plan, which has a combined out-of-pocket maximum.

Note: Certain preventive medications (such as certain contraceptives and smoking cessation products (generic only unless no generic is available or the generic is medically inappropriate)), when prescribed by your Physician, are available without any copay as required under the Affordable Care Act. To find out if a particular preventive medication will be paid at 100%, contact the Pharmacy Benefit Manager or see the list of preventive services, including women’s preventive services, located at <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

Out-of-Pocket Maximum

Employee	\$2,000
Employee + 1 Dependent	\$4,000
Employee + 2 or more Dependents	\$6,000

Note: This separate Out-of-Pocket Maximum does not apply to Participants in the HDHP with HSA – since it has a combined medical and prescription drug out-of-pocket maximum.

Retail Benefit (30-day fill)

Per Prescription Copay	Generic: \$10 Preferred Brand: 20% (\$30 minimum / \$50 maximum) Non-Preferred Brand: 30% (\$50 minimum / \$75 maximum)
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Caveats:

- If you are a Participant in the HDHP with HSA Plan, you must first satisfy the applicable deductible; after you have satisfied the applicable deductible, the Copays set forth above will apply. However, generic medications which are included on the IRS's preventive drug list but not on the ACA preventive drug list will be available subject to the generic copay specified here prior to satisfaction of the deductible.
- If a Participant purchases a brand name medication when a generic is available, the Participant must pay the generic copay **plus** the difference in price between the brand name and generic medication. In such cases, only the generic copay will count towards the out-of-pocket maximum for prescription drugs; and the price differential will not.
- At CVS Pharmacies (actual CVS pharmacies, not just pharmacies in the CVS network), prescriptions can be filled with a 30-day supply per prescription copay or a 90-day supply for two retail prescription copays.
- Benefits at pharmacies other than CVS Pharmacies are limited to a 30-day supply per prescription copay.
- Prescriptions for maintenance medication (except controlled substances) will only be refilled two times and then the Participant has two options: use the Mail Order Benefit or obtain a 90-day supply from a CVS Pharmac

Mail Order Benefit (up to a 90-day fill)

Per Prescription Copay

Generic: \$20
Preferred Brand: 20% (\$60 minimum / \$100 maximum)
Non-Preferred Brand: 30% (\$100 minimum / \$150 maximum)

Caveats:

- If you are a Participant in the HDHP with HSA Plan, you must first satisfy the applicable deductible; after you have satisfied the applicable deductible, the Copays set forth above will apply. However, generic medications which are included on the IRS's preventive drug list but not on the ACA preventive drug list will be available subject to the generic copay specified here prior to satisfaction of the deductible.
- If a Participant purchases a brand name medication when a generic is available, he must pay the generic copay **plus** the difference in price between the brand name and generic medication. In such cases, only the generic copay will count towards the out-of-pocket maximum for prescription drugs; and the price differential will not.
- Mail Order Benefits are limited to a 90-day supply per prescription copay. If the prescription is for less than a 90-day supply (e.g. 30 or 45 days), the same mail order prescription copay will apply.

Specialty Medications

Specialty Pharmacy

Plan pays 60%; you pay 40%*
30-day supply dispensed

Limited Distribution Drugs not available
from the Specialty Pharmacy
Copays set forth above

30-day supply subject to Retail

Caveats:

- If you are a Participant in the HDHP with HSA Plan, you must first satisfy the applicable deductible; after you have satisfied the applicable deductible, the coinsurance set forth above will apply.
- Prescriptions for Specialty Medications should be filled exclusively through the Pharmacy Benefit Manager's Specialty Pharmacy. (The only exception would be Limited Distribution Drugs (LDD) that are not available from the Specialty Pharmacy; you will be notified if the

Specialty Pharmacy is unavailable to dispense a medication and directed as to how to fill your prescription.) This requirement applies even with respect to Specialty Medications dispensed by a Physician in a Physician's office.

D. Schedule of Benefits: Vision Care

Vision care benefits may be offered subject to the maximums, benefit percentages, and copayments as listed below at the option of the Member Agency. Please contact the Vision Claims Processor identified on page 5 for additional information regarding the vision care benefits provided under the Plan.

You will be reimbursed on an in-network basis (as specified below) only if the in-network provider submits the claim directly to the Vision Claims Processor at the time services are rendered. If the in-network provider does not do so, you may later submit your claim to the Vision Claims Processor, but it will be paid on an out-of-network basis.

Out-of-Pocket Maximum

There is no out-of-pocket maximum that applies to vision care benefits.

Calendar Year Benefit Maximums

Allowance Plans – In-Network	\$200, \$400, or \$600 as selected by the Member Agency
Allowance Plans – Out of Network	\$150, \$300, or \$450 as selected by the Member Agency
Silver Managed Plan In-Network Vision Care Frames/Contacts	\$150 per Calendar Year for frames/contacts not included in the Vision Claims Processor’s exclusive collection
Gold Managed Plan In-Network Vision Care Frames/Contacts	\$250 per Calendar Year for frames/contacts not included in the Vision Claims Processor’s exclusive collection
Managed Plans Out-of-Network Vision Care	\$45 per eye exam \$50 per frames \$40 for single-vision lenses \$60 for bifocal/progressive lenses \$80 for trifocal lenses \$100 for lenticular lenses \$105 for elective contact lenses

\$225 for visually required contact lenses

Benefit Percentages/Copayments

Allowance Plans In-Network Vision Care	100%; no deductible Eye exam covered 100%, does not count towards Allowance Plan Maximum
Allowance Plans Out-of-Network Vision Care	100%; no deductible Eye exam covered 100% up to \$45, does not count towards Allowance Plan Maximum
Managed Plans In-Network Vision Care	100% after copays as specified; no deductible
Eye exam	\$0 copay
Clear plastic lenses	\$0 copay
Polycarbonate lenses	\$0 copay (children)/\$30 copay (adults)
High-index lenses 1.67	\$55 copay
High-index lenses 1.74	\$120 copay
Polarized lenses	\$75 copay
Progressive lenses	\$50 (standard), \$90 (premium), \$140 (ultra), or \$175 (ultimate) copay
Anti-reflective coating	\$35 (standard), \$48 (premium), \$60 (ultra), or \$85 (ultimate) copay
Ultraviolet coating	\$12 copay
Tinting	\$0 copay
Plastic photochromic lenses	\$65 copay
Scratch-resistant coating	\$0 copay
Premium scratch-resistant coating	\$30 copay
Scratch protection plan	\$20 (single-vision) or \$40 (multifocal)
Digital single vision lenses	\$30 copay
Trivex lenses	\$50 copay
Blue light filtering	\$15 copay
Retinal imaging	\$39 copay

E. Description of In-Network Provider Coverage

In-network providers are Hospitals, Physicians or other providers who have agreed to provide health care services to Plan Participants at negotiated rates. An in-network provider list will be furnished promptly upon request and without charge to Employees. As specified in this article, in-network provider benefits are generally higher than out-of-network provider benefits.

Subject to the exclusions, conditions, and limitations stated in this document, the Plan will pay benefits to or on behalf of a Participant for covered medical expenses described in this article up to the maximum amounts specified in the Schedule of Benefits.

Services must be furnished by an eligible provider and must be Medically Necessary.

The obligation of this Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred by the Participant if all provisions mentioned in this document are satisfied. All payments made under this Plan for allowable charges will be based on the Reasonable and Customary Charge.

The fact that certain Physicians, Hospitals, or other providers are “in-network,” as discussed here, should not be construed as a recommendation, referral or any other statement as to the ability or quality of such Physicians, Hospitals, or other providers, and neither the Plan nor the Plan Administrator bears any liability for any act or omission of such Physicians, Hospitals, or other providers. Conversely, the fact that certain Physicians, Hospitals, or other providers are “out-of-network” should not be construed as a statement, negative or positive, as to the skill or quality of such Physician or Hospital.

F. Description of Out-of-Network Provider Coverage

1. GENERAL

Out-of-network providers are Hospitals, Physicians or other providers who have not agreed to provide health care services to Plan Participants at negotiated rates. As specified in this article, out-of-network provider benefits are generally less than in-network provider benefits.

Subject to the exclusions, conditions, and limitations stated in this document, the Plan will pay benefits to or on behalf of a Participant for covered medical expenses described in this article up to the maximum amounts specified in the Schedule of Benefits.

The Plan will pay benefits for the Reasonable and Customary Charges (unless specified otherwise) for services and supplies which are ordered by a Physician. Services must be furnished by an eligible provider and must be Medically Necessary.

The obligation of this Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred

by the Participant if all provisions mentioned in this document are satisfied. All payments made under this Plan for allowable charges will be limited to the Reasonable and Customary Charge (except to the extent otherwise specified).

Generally, out-of-network providers may bill a Plan Participant for the amount in excess of the Reasonable and Customary Charges. The Plan Participant will be liable for such payment. The amount in excess of the Reasonable and Customary Charges will not apply to the Participant's out-of-pocket maximum. Notwithstanding the preceding, out-of-network providers of Emergency Services, out-of-network air ambulance providers, and certain out-of-network providers performing services at in-network facilities are restricted in their ability to balance bill for charges above legally determined amounts. Participants will receive more information as to these restrictions in the explanations of benefits with respect to relevant claims.

2. TREATMENT OF EMERGENCY MEDICAL CONDITION BY AN OUT-OF-NETWORK PROVIDER

Covered medical expenses for treatment of an Emergency Medical Condition by an out-of-network provider shall be paid at 100% of the Out-of-Network Rate (as defined) after payment of the \$100 copay.

3. TREATMENT BY AIR AMBULANCE PROVIDERS

Covered medical expenses for air ambulance (medical transport by fixed wing airplane or rotary wing helicopter) services shall be paid on the same basis regardless of whether the provider is a network provider (Tier 1 or Tier 2) or an out-of-network provider (Tier 3), and the Participant's cost-sharing responsibility will be calculated based on the lesser of the billed amount for the services of the median of the network's contracted rates with participating providers in the geographic region for the respective services as of January 31, 2019, indexed for inflation thereafter, and any co-insurance payments the Participant makes with respect to covered air ambulance services will count toward the Tier 1 and Tier 2 in-network deductible and out-of-pocket maximum, regardless of whether received from a Tier 1 or Tier 2 or Tier 3 network or out-of-network provider.

4. TREATMENT BY AN OUT-OF-NETWORK PROVIDER AT A NETWORK FACILITY.

Covered medical expenses for non-Emergency treatment by an out-of-network provider at a network facility will be paid with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a network provider. In other words, the coinsurance/benefit percentage and any copayments applicable to such services will be the same as if the services were furnished by a network provider as set forth in the Schedule of Benefits.

The Plan Participant's coinsurance responsibility will be based on the Out-of-Network Rate, and any cost-sharing payments made with respect to covered non-Emergency services will count towards the in-network deductible and in-network out-of-pocket maximum in the same manner as if the services were furnished by a network provider.

An exception will apply with respect to certain non-network providers who have provided notice to the patient and receive informed consent with respect to out-of-network billing practices in compliance with applicable law. If the exception applies, the applicable out-of-network coinsurance/benefits percentage to be paid by the Plan will be based on the Reasonable and Customary Charge, and the out-of-network deductible and out-of-pocket maximum will apply. No exception is available, however, with respect to provider of Ancillary Services or with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or services is furnished, regardless of whether the notice and consent requirements have been satisfied.

5. TREATMENT AT A FACILITY OF THE UNIFORMED SERVICES OR INDIAN HEALTH CARE

Where treatment is rendered at a facility of the uniformed services or Indian Health Care facility, covered expenses with respect to services, supplies or treatments rendered by an out-of-network provider shall be payable at the in-network provider level of benefits.

6. CONTINUITY OF CARE

If a provider or facility ceases to be an in-network provider due to termination of the provider or facility's contractual relationship with the Plan's network (except for termination due to fraud or failure to meet applicable quality standards), a "continuing care patient" may elect continued transitional care for a 90-day period from such provider or facility with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in-network. This will allow you time to transition your care to a network provider.

An individual is a continuing care patient if the individual (a) is undergoing a course of treatment for a "serious and complex condition" from the provider or facility; (b) is undergoing a course of institutional or inpatient care from the provider or facility; (c) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (e) is or was determined to be "terminally ill" and is receiving treatment for such illness from such provider or facility.

An individual has a serious and complex condition if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is six months or less.

7. SERVICES OR SUPPLIES OBTAINED FROM OUT-OF-NETWORK PROVIDER BELIEVED TO BE AN IN-NETWORK PROVIDER

If a Participant receives information through the public website database or provider directory made available by the Plan or its Claims Processor, or in response to a direct request for information,

indicating that a provider is an in-network provider, and the Participant, in reliance upon such information, obtains supplies or services from an out-of-network provider in the belief that the provider is an in-network provider, benefits will be paid as if the provider were, in fact, in-network, subject to application of the in-network benefit percentage/coinsurance rates, copayments, benefit maximums, deductibles and out-of-pocket maximums.

G. Affordable Care Act: Notice of Patient Protection Rights

Under the Plan, you are not required to designate a Primary Care Physician, and you are free to see any Physician you wish, including pediatricians. Also, you do not need prior authorization from the Plan, the Preferred Provider Organization, the Claims Processor, or any other person or entity (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. (Indeed, under the Plan, Family Practitioners, General Practitioners, Internists, Pediatricians and Obstetricians/Gynecologists all are considered to be "Primary Care Physicians." You do not need prior authorization to receive care from a specialist. The only services requiring prior authorization under the Plan are described in Sub-sections A and B of Section IV. Care Management.)

H. Costs

1. BENEFIT PERCENTAGES

After satisfaction of any applicable deductible, the Plan will provide the level of payment indicated in the Schedule of Benefits depending on which tier the provider is in. The Participant is responsible for the remaining percentage. *Note:* Unless otherwise indicated, benefit percentages are paid based on the Reasonable and Customary Charge.

2. COPAYMENTS

A Participant may be assessed a per-service charge for Physician office visits, Urgent Care Facility visits, Outpatient psychotherapy, allergy and vitamin injections, acupuncture and chiropractic visits and prescription drugs according to the Schedule of Benefits.

3. DEDUCTIBLE

a) Level

Per Individual per Calendar Year:	See Schedule of Benefits.
Per Employee plus one Dependent per Calendar Year:	See Schedule of Benefits
Per Employee plus two or more Dependents per Calendar Year:	See Schedule of Benefits.

b) Applicability

Common Accident: If two or more covered Family members are injured in the same Accident, those injured will be required to satisfy only one individual deductible between them for covered Medical Expenses related to the same Accident for each Calendar Year that such Accident-related expenses are incurred.

Amounts applied towards the deductible for each tier of provider (Tier 1, 2, or 3) shall also be applied towards the deductible for any other tier.

c) Application of HRA

A portion of the in-network deductible may be offset by reimbursements from a health reimbursement account (“HRA”) that the Employee’s Employer has opted to make available in combination with the \$1,250, \$1,500, \$2,000, \$2,500 or \$3,500 Deductible plan. To determine whether HRA benefits are available to offset a portion of the in-network deductible, contact your Benefits Coordinator. If HRA benefits are available, first the Participant will pay a portion of the in-network deductible (the pre-HRA amount shown in the applicable Schedule of Benefits). Then, the HRA will reimburse up to the amount shown in the applicable Schedule of Benefits.

HRA benefits are available only with respect to Covered Charges that are applied to the in-network (Tier 1 or Tier 2) deductible. HRA benefits are not available with respect to any other expenses (such as copays, coinsurance, or the out-of-network deductible). HRA benefits also are not available with respect to those Covered Charges from “unsolicited” out-of-network providers that may under limited circumstances be applied to the in-network deductible as explained above.

There is no need to submit a separate claim for reimbursement from the HRA. HRA benefits automatically will be paid (if available) when a Participant or the Participant’s provider submits a claim for benefits under the Plan.

If an Employee does not use up the amount available under the HRA benefit in a given year, that amount will not roll over to a future year.

If an Employee or the Employee’s Dependent becomes entitled to COBRA Continuation Coverage or IMRF Continuation Coverage due to a loss of eligibility for Plan coverage as described in this document, that coverage will include HRA benefits.

d) Application of HSA

For Participants in the HDHP with HSA Plan, the deductible and other out-of-pocket expenses such as copays and coinsurance may be offset by reimbursements from a Participant’s health savings account (“HSA”).

4. OUT-OF-POCKET MAXIMUMS

The maximum amount a Participant must pay (including deductibles) toward eligible expenses. Penalties do not apply to the out-of-pocket maximum, nor do amounts in excess of the Reasonable and Customary Charge and amounts not covered by the Plan. Per service copays will apply to the out-of-pocket maximum.

Amounts applied towards the out-of-pocket maximum for each provider tier (Tier 1, 2, or 3) shall also be applied towards the out-of-pocket maximum for any other tier, unless otherwise specified.

Prescription drug copays are subject to a separate out-of-pocket maximum as listed in the schedule of benefits above. There is no out-of-pocket maximum with respect to vision benefits.

I. Description of Medical, Vision, and Prescription Drug Benefits

1. ABORTION

Induced termination of a Pregnancy by any medically acceptable means.

2. ALLERGY INJECTIONS AND SURVEYS

Allergy injections and surveys are covered as part of the medical benefits, subject to applicable deductibles and out-of-pocket maximums and payable at the applicable coinsurance rates as set forth in the medical Schedules of Benefits above.

3. AMBULANCE SERVICE

Professional ambulance service to and from the Hospital. In the event that a Sickness or Injury requires specialized emergency treatment not available at a local Hospital, transportation for such treatment is covered when ordered by a Physician. The transportation within the United States and Canada must be by regularly scheduled airlines or railroad or by rotary or fixed wing air ambulance. The covered transportation is only from the city or town where the Emergency Medical Condition occurred to the nearest Hospital or facility qualified to render special treatment.

4. AMBULATORY SURGICAL CENTER

Facility charges for procedures performed in an Ambulatory Surgical Center and associated services and supplies.

5. AUTISM

The following treatment for Autism Spectrum Disorders will be covered if determined to be Medically Necessary:

- Psychiatric care
- Psychological care
- Habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- Therapeutic care, including behavioral, speech, occupational and physical therapies addressing the following areas:
 - Self-care and feeding
 - Pragmatic, receptive, and expressive language
 - Cognitive functioning
 - Applied behavioral analysis, intervention, and modification (subject to prior authorization by the Medical Care Management Organization)
 - Motor planning
 - Sensory processing

6. BIRTHING CENTERS

Facility charges for procedures performed in a Birthing Center and associated services and supplies.

7. CHEMOTHERAPY

A regimen comprised of a single agent or a combination of anti-cancer agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs.

Drug Requirements

- Use that is included as an indication on the drug's label as approved by the FDA or
- Use of an FDA-approved drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major drug compendia, medical literature, and/or accepted standards of medical practice.
- Use of drugs to treat toxicities or side effects of the cancer treatment regimen when the drug is administered in relation to chemotherapy, including off-label uses supported by medical literature.

8. CHIROPRACTIC TREATMENT

Examinations, diagnostic evaluations and treatments by manipulation and other modalities, including maintenance care.

9. COCHLEAR IMPLANTS

Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Physician.

10. DENTAL CARE FOR ACCIDENTAL INJURY

Treatment of Accidental Injuries to the jaw, mouth, or sound natural tooth (a tooth which is free of decay but may be restored by fillings, has a live root, and does not have a cap or crown).

11. DIAGNOSTIC SERVICES

Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient, not in connection with routine physical examinations except as specified in this Plan Document. Covered expenses include:

- Pathology
- Radiology
- Physician's Interpretation.

12. DIALYSIS SERVICES -- OUTPATIENT

Charges incurred in connection with outpatient dialysis treatment, including:

- Dialysis-related services, equipment and supplies,
- Injectable drugs and their oral forms and biologicals, including erythropoiesis-stimulating agents used for dialysis treatment,
- Laboratory test and other items and services provided in connection with dialysis treatment, and

- Home dialysis training.

13. DURABLE MEDICAL EQUIPMENT

- Rental or initial purchase (whichever is less expensive, subject to approval by the Plan) of Durable Medical Equipment. Replacement or repair of Durable Medical Equipment when Medically Necessary due to physiological change to the patient, due to normal wear and tear of the item or the existing equipment is damaged and cannot be made serviceable. The Medical Care Management Organization will determine Medical Necessity and the most cost-effective method of providing certain higher cost Durable Medical Equipment (such as, but not limited to electric wheelchairs).

14. EMERGENCY ROOM SERVICES

Emergency Services (as defined) are covered as set forth in the Schedule of Benefits.

Example Emergency Services that could be included (not an exhaustive list):

- Emergency room facility charges,
- Emergency room Physician charges,
- Various treatments, screenings, tests and other services administered to stabilize the patient.

Post-stabilization services provided by non-network providers and facilities will be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services as set forth in the Schedule of Benefits unless certain conditions are met. Post-stabilization services include outpatient observation and inpatient or outpatient stays with respect to the visit in which other Emergency Services are furnished.

Post-stabilization services at a non-network facility or from a non-network provider are not considered Emergency Services for payment purposes if (i) the attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition, (ii) the non-network facility or provider furnishing such services provides adequate notice as to non-network billing practices to the patient as required by federal law and receives informed consent from the patient to continued treatment despite the greater cost, in compliance with applicable law.

Note: Ambulance services (both ground and air) are covered as described in Section 3 Ambulance Services above.

15. GENDER REASSIGNMENT SURGERY, TREATMENTS, SERVICES AND SUPPLIES

Gender reassignment surgery, treatments, services and supplies will be covered, including, but not limited to the following:

- Hormonal therapy, including related lab tests and specialist office visits

- Prescription drugs
- Pre-surgical evaluation
- Gender reassignment surgery for individuals age 18 or over, including all inpatient, Outpatient and related follow-up care
- Breast augmentation or breast reduction surgery for individuals age 18 or over, including all inpatient, Outpatient and related follow up care.

Certain gender reassignment services must be determined by the Medical Care Management Organization to be Medically Necessary; thus it is recommended that the Participant and/or the provider contact the Medical Care Management Organization to discuss which services are subject to clinical review prior to receiving services.

Notwithstanding anything herein to the contrary, mental health counseling related to gender dysphoria and related conditions and to gender reassignment will be covered on the same basis as any other mental health counseling and will not be subject to prior authorization.

16. GENE THERAPY

Gene therapy will be covered if determined to be Medically Necessary by the Medical Care Management Organization.

17. HEARING AIDS

Hearing aids if provided in-network with referral up to the maximum stated on the Schedule of Benefits no more frequently than once every sixty months. Free hearing exam included. This benefit is offered through EPIC Hearing Healthcare.

18. HOME HEALTH CARE SERVICES

a) Services

Part-time or intermittent nursing care provided or supervised by a Registered Nurse (R.N.) to the limit provided for Nursing Care; part-time or intermittent home health aide services, primarily for the patient's medical care; physical, occupational, speech, or respiratory therapy by a licensed qualified therapist; nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, drugs, and medications prescribed by a Physician. One Home Health Care Agency visit is considered 4 or less hours of nursing care. For example, 8 consecutive hours of nursing care will be considered 2 visits. Benefits are limited to the maximums stated in the Schedule of Benefits.

b) Requirements

Services must be provided in the patient's home under a written plan of the patient's attending Physician's stating the diagnosis, certifying that the home health care is in lieu of Hospital or Other Confinement, and further specifying the type and extent of treatment.

19. HOSPICE CARE EXPENSES

Benefits are limited to the maximums stated in the Schedule of Benefits.

a) Services

- Hospice room and board while the terminally ill person (diagnosed by the attending Physician as having six months or less to live) is an inpatient in a Hospice;

- Outpatient and other customary Hospice services provided by a Hospice or Hospice team; and
- Counseling services provided by a member of the Hospice team.

b) Requirements

These services and supplies are eligible only if the hospice operates as an integral part of a Hospice Care Agency and the hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be:

- Provided under a Hospice Care Agency program that meets standards set by the Plan. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement;
- Provided while the terminally ill person is in a hospice care program; and
- Ordered by the doctor directing the hospice care program.
- Bereavement counseling services for the family unit must be ordered and received under the hospice care program; on the day before death the terminally ill person must have been in a hospice care program, a member of the family unit, a covered Participant; and charges must be incurred within three months after the death.

20. HOSPITAL OR OTHER CONFINEMENT

a) Room and Board

Semi-private room accommodations, including general nursing services. Room charges made by a Hospital having only private rooms will be paid as if the room were a semi-private room. Expenses for special care units, including general nursing services. Special care units include Intensive Care Units, cardiac care units, respiratory care units, step down units, emergency care facilities, and other units considered by the Plan to be special care units.

If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.

b) Hospital Services and Supplies

Benefits will be payable for Medically Necessary services and supplies furnished during a covered Hospital or Other Confinement, including, but not limited to, the following:

- Meals and special diets
- Operating and recovery rooms
- Drugs and medicines required during a period of confinement
- Oxygen and the use of equipment for its administration
- Laboratory and pathological tissue examinations
- Dressings and casts
- Thyroid function studies
- Blood transfusion services
- X-ray and other radiological examinations
- Electrocardiograms
- Electroencephalograms
- Physical therapy
- Inhalation therapy

- Use of heart-lung equipment
- Kidney dialysis services
- Anesthesia services
- Use of anesthesia equipment
- Radioactive materials and radiation therapy
- Diagnostic services

21. HOSPITAL OUTPATIENT TREATMENT

Services rendered in an Outpatient department of a Hospital, including, but not limited to, the following:

- Allergy testing
- Chemotherapy
- Emergency Services
- Laboratory Tests and X-rays
- Outpatient shock therapy
- Pre-Admission Testing
- Radiation Therapy
- Respiratory Therapy
- Surgical Services
- Intensive Outpatient programs, partial hospitalization or day programs, support groups, and after care for the treatment of Mental Health Disorders and Substance Abuse Disorders that does not include overnight stays at the facility.

22. INFERTILITY TESTING/TREATMENT

a) Services

Diagnosis and treatment of infertility will be covered, including but not limited to coverage for the following:

- In vitro fertilization
- Uterine embryo lavage
- Embryo transfer
- Artificial insemination
- Gamete intrafallopian tube transfer
- Zygote intrafallopian tube transfer
- Low tubal ovum transfer
- Fertility preservation services

b) Requirements

Coverage for procedures for in vitro fertilization, Gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer will be provided only if:

- The covered individual has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments for which coverage is available under the Plan; and
- The covered individual has undergone less than 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals will be covered; and
- The procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

23. MENTAL HEALTH

Services and supplies to treat Mental Health Disorders are covered on the same basis as services and supplies to treat any other Sickness.

24. NEWBORN CARE EXPENSES

Covered expenses for a sick or well newborn child incurred for Hospital and Physician services while the mother is confined for delivery will be added to the covered expenses of the mother to determine allowable benefits payable (one deductible, one copayment). This will apply whether or not the newborn is subsequently enrolled for Dependent benefits.

All Medically Necessary Physicians' services for the newborn while confined in the Hospital following birth will be covered.

Payment for covered expenses after the mother's discharge or the newborn's discharge (whichever is first) will be made on the same basis as for any other Sickness provided the Employee has properly enrolled the child for Dependent benefits, and Dependent benefits are effective.

25. NUTRITIONAL COUNSELING

Nutritional counseling by a Licensed or Registered Dietician or Licensed Nutritionist for nutrition-related and weight-related medical conditions.

26. OBESITY TREATMENT

Treatment of Morbid Obesity, endogenous obesity, and non-Morbid Obesity. Coverage for surgical treatment of obesity will be limited to one procedure per Lifetime and will be available only to patients with Morbid Obesity. Benefits for non-surgical treatment by a Physician of any kind of obesity will be limited to office visits, behavior modification, nutritional counseling (as described above), and required X-ray and laboratory examinations or as otherwise required under the Affordable Care Act. Coverage may also be available for weight loss medications subject to prior authorization if and to the extent elected by the employee's employer.

Surgical treatment of Morbid Obesity is subject to prior authorization by the Medical Care Management Organization and will be limited to Participants who meet ALL of the following criteria:

1. Presence of Morbid Obesity that has persisted for at least five years, defined as a BMI exceeding 40 or a BMI greater than 35 in conjunction with any of the following co-morbidities: coronary heart disease, diabetes mellitus, clinically significant obstructive sleep apnea, dyslipidemia, hypertension or osteoarthritis in weight bearing joints.
2. Patient has completed growth (18 years of age).
3. Patient has attempted weight loss in the past without successful long-term weight reduction.
4. Patient has been educated in and understands the post operative regimen and is willing to comply.
5. Patient has participated in a Physician-supervised nutrition and exercise program documented in the patient's medical records as submitted by the Physician. This Physician-supervised nutrition and exercise program must meet ALL of the following criteria:
 - Must be supervised and monitored by a Physician working in cooperation with a Licensed Dietician (L.D. or L.D.N.).
 - Must be six months or longer in duration.
 - Must occur within the two years prior to surgery.
 - Must be documented in the patient's medical record as submitted by an attending Physician who does not perform bariatric surgery.

27. ORAL SURGERY

Benefits are limited to the following procedures:

- Excision of impacted teeth
- Excision of tumors or cysts from the mouth
- Apicoectomy (excision of tooth root without excision of the tooth)
- Cutting procedures on the gums and mouth tissues for treatment of disease
- Osseous surgery
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures)
- Treatment of fractures of facial bones
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the covered person has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting.

28. ORGAN TRANSPLANTS

a) Services

Covered expenses related to non-Experimental human organ transplants which are Medically Necessary. Covered procedures include, but are not limited to:

- Bone Marrow
- Cornea
- Heart
- Heart/lung

- Kidney
- Liver
- Lung
- Pancreas

The Plan will also cover any other types of human organ transplants that become accepted as non-Experimental procedures, as determined by the Plan Administrator. Covered Charges include acquisition cost and drugs, even if not otherwise covered under this Plan.

Transplant-related expenses incurred by a living donor may be covered, subject to coordination with any other medical benefits covering the donor and subject to the Participant's maximum benefits payable under this Plan. Any fee or charge made by the donor for such organ(s) will not be considered a covered medical expense.

If only the donor is covered under the Plan, no benefit is available.

When the transplant procedure has been determined to be Medically Necessary and is being coordinated by the Medical Care Management Organization (see Section IV) and is performed at an organ transplant Network site recommended and approved by the Medical Care Management Organization and more than 50 miles away from the Participant's residence, the following travel-related expenses will be covered. These benefits are limited to the patient and one other individual (in the case of a minor, two other individuals) for the following:

- Transportation to and from site
- All reasonable and necessary lodging and meal expenses

All travel-related expenses are payable at 100% and are limited to the maximums stated in the Schedule of Benefits.

b) Requirements

Transplants: Any human solid organ or bone marrow/stem cell transplant provided that:

- 1) The condition is life-threatening; and
- 2) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, Federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
- 3) The patient is a suitable candidate for the transplant approved by the Medical Care Management Organization.

29. ORTHOTIC APPLIANCES AND DEVICES

The initial purchase of Orthotic Appliances and/or Devices, including but not limited to foot orthotics, provided that such appliances and/or devices are prescribed by a Physician. Replacement or repair of Orthotic Appliances and/or Devices when Medically Necessary due to physiological change to the patient, due to normal wear and tear of the item or where the existing equipment is damaged and cannot be made serviceable.

30. PHYSICAL/OCCUPATIONAL THERAPY

Medically Necessary services, as certified by a Physician, rendered by a certified or licensed physical therapist or registered occupational therapist. Therapy rendered by a licensed therapist to restore the

loss or impairment of motor functions resulting from illness, disease or Injury. Maintenance Care is not covered. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

31. PHYSICIAN SERVICES

a) Hospital Inpatient

Inpatient Services and Medically Necessary consultations by a Physician to a Hospital inpatient.

b) Physician Home/Office Visits

Services and supplies provided by a Physician in a professional office or in the home of the Participant when Medically Necessary.

c) Other

Reasonable and necessary services of a Physician. Covered services include, but are not limited to, the following:

- Allergy Injections*
- Allergy Testing
- Cardiac Rehabilitation
- Chemotherapy*
- Dermatology Testing
- Emergency Services
- Infusion Therapy*
- Injections*
- Interpretation of Diagnostic Tests
- Radiation Therapy
- Respiratory Therapy

*Note: Specialty Medications should be obtained through the Pharmacy Benefit Manager Specialty Pharmacy.

32. PREADMISSION TESTING

Services incurred for Outpatient preadmission testing required prior to surgery provided:

- Inpatient surgery has been scheduled; and
- The tests have been ordered by the attending Physician and performed within 7 days prior to admission; and
- The tests are performed at the Hospital where the surgery will be done; and
- The patient is subsequently admitted to the Hospital or the admission is cancelled or postponed due to circumstances beyond the patient's control.

33. PREGNANCY

This Plan shall not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. This Plan shall not require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods, and nothing is to prevent the mother's or newborn's attending health care provider and the mother from agreeing to an earlier discharge.

Regular Plan benefits (as specified in the applicable sections of this document) are payable for expenses incurred by the Employee, spouse, Civil Union Partner, Domestic Partner or Dependent child.

Services required for the normal management of Pregnancy, including any condition usually associated with the management of a difficult Pregnancy but not considered a complication of Pregnancy. Antepartum and postpartum care of the mother is included.

Services required for the treatment of complication of Pregnancy, including any physical effect directly caused by Pregnancy but considered to be an effect of a normal Pregnancy, conditions related to ectopic Pregnancy or conditions requiring cesarean section.

Care for Miscarriage.

Expectant mothers with a high risk pregnancy are encouraged to call the PPO Maternity Management Service for a voluntary screening and to gain access to nurses with information about prenatal care.

34. PRESCRIPTION DRUGS

a) Retail Drug Benefit

If a Participant incurs expenses for prescription drugs at a participating pharmacy, the Plan will pay 100% of the cost of the prescription minus the per prescription copayment listed on the applicable prescription drug schedule (except that Participants in the HDHP with HSA Plan must first meet the applicable deductible). In other words, the Participant will have to pay only the per prescription copayment amount. The pharmacy will submit the claim to the Pharmacy Benefit Manager, and the Pharmacy Benefit Manager will reimburse the pharmacy.

At nonparticipating pharmacies, the Participant must pay the entire cost of the prescription. For reimbursement, a prescription drug claim form must be completed by the Participant and sent to the prescription drug plan for processing. The Participant will be reimbursed for the discounted cost of the prescription minus the per prescription copayment amount listed on the applicable prescription drug schedule (except that Participants in the HDHP with HSA Plan must first meet the applicable deductible). The Participant will not be reimbursed for any amounts above the discounted cost.

If a Participant purchases a brand name medication when a generic is available, the Participant must pay the generic copay **plus** the difference in price between the brand name and generic medication. In such cases, only the generic copay will count towards the out-of-pocket maximum for prescription drugs; and the price differential will not.

Benefits at pharmacies other than CVS Pharmacies are limited to a 30-day supply per prescription copay.

At CVS Pharmacies (actual CVS pharmacies, not just pharmacies in the CVS network), prescriptions can be filled with a 30-day supply per prescription copay or a 90-day supply of maintenance medications for two retail prescription copays.

Prescriptions for maintenance medication (except controlled substances) will only be refilled two times at the retail pharmacy and then the Participant has two options: use the Mail Order Benefit or obtain a 90-day supply from a CVS Pharmacy.

b) Mail Order Drug Benefit

If a prescription is filled via mail order, the Participant will pay the Mail Order Benefit prescription copay set forth on the applicable prescription drug schedule for a 90-day supply, and the Plan will pay the remainder of the cost.

This benefit is particularly beneficial for those individuals who take regular medication over an extended period of time (maintenance medication). Maintenance medication is usually associated with the treatment of illnesses including, but not limited to, anemia, arthritis, diabetes, emotional distress, epilepsy, heart disorders, high blood pressure, thyroid or adrenal conditions and ulcers.

c) Specialty Medications

Prescriptions for Specialty Medications should be filled exclusively through the Pharmacy Benefit Manager's Specialty Pharmacy. This includes Specialty Medications dispensed by a Physician in the Physician's office. The only exception is certain Limited Distribution Drugs not available from the Specialty Pharmacy; you will be notified if this is the case and instructed as to how to obtain the medication. You can enroll in the Specialty Pharmacy program by calling 1-800-237-2767. The Specialty Pharmacy program ships your medicine to you, your provider, or a local CVS Pharmacy (if available).

The prescription coinsurance for a 30-day supply of a Specialty Medication generally will be the coinsurance set forth on the prescription drug schedule with respect to Specialty Medications. The exception is Limited Distribution Drugs not available from the Specialty Pharmacy, these drugs will be subject to the copayments set forth on the applicable schedule with respect to drugs purchased at retail. Another exception will apply with respect to Specialty Medications available through the PrudentRx Copay Program as set forth below.

PrudentRx Copay Program for Specialty Medications

PDRMA currently offers the PrudentRx Copay Program with respect to certain Specialty Medications. The program helps you to enroll in manufacturer co-pay assistance programs that may be available with respect to certain Specialty Medications. Copay assistance is a process through which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications. If you enroll in the PrudentRx Copay Program, your out-of-pocket cost for prescriptions covered under the PrudentRx Copay Program will be reduced to \$0. If you are enrolled in a HDHP with HSA Plan, you must first meet the applicable deductible before your out-of-pocket cost can be reduced to \$0. (If you choose not to enroll, you will be required to pay the coinsurance set forth in the Schedule of Benefits.)

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. The PrudentRx patient advocate will help you enroll in the PrudentRx Copay Program and any available manufacturer copay assistance programs.

If you or a covered dependent is prescribed a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or PrudentRx will proactively contact you.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your applicable deductible.

Because certain Specialty Medications do not qualify as Essential Health Benefits under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of Specialty Medications that are not considered to be Essential Health Benefits is available from PrudentRx or at <https://www.prudentrx.com/prudentexf/>.

PrudentRx can be reached at 800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

d) Prior Authorization

Prior authorization may be required for certain prescription drugs (or with respect to the prescribed quantity of a particular drug). Prior authorization helps promote appropriate utilization. If you are filling your prescription in a retail setting, at the time you fill the prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system. The Pharmacy Benefit Manager may contact your Physician if additional information is required to determine whether prior authorization should be granted. The Pharmacy Benefit Manager communicates the results of the decision to both you and your Provider. If prior authorization is denied, you have the right to appeal through the appeals process outlined with respect to pre-service claims in the Claims Procedures section of this document. Prior authorization also may be required for certain Specialty Medications to be obtained through the Specialty Pharmacy; the Specialty Pharmacy will guide you through this process.

e) Step Therapy

In many instances there are a number of drugs available and clinically effective to treat a particular Sickness or Injury. Before you get coverage for certain brand name medications, the Plan may require that you first try one or more available generic or different brand medications in the therapeutic class. If you elect to purchase the original brand medication without trying the appropriate generic or alternative brand medication(s) as required, you will pay the full cost of the drug. If you try the generic or alternative brand medications, and the Plan determines that generic or alternative medications are not effective in treating your condition, you may be able to receive the original brand medication at the applicable brand copay. This does not apply to those brand name prescriptions for which there is a direct generic equivalent available. In those instances, if you decide to take the brand when there is a direct generic equivalent available, you will be required to pay the difference in cost plus the generic copay.

When you request to fill a prescription for a drug subject to step therapy as described above, the pharmacist or Pharmacy Benefit Manager will alert you to the need to try an alternative medication first.

f) Copays

The applicable copays for prescription drugs are set forth in the Schedule of Benefits. If you purchase a brand name medication when a generic is available, you must pay the generic copay **plus** the difference in price between the brand name and generic medication. In such cases, only the generic copay will count towards the out-of-pocket maximum for prescription drugs; the price differential will not. Copays will cease to apply when you have met the applicable prescription drug out-of-pocket maximum (or the combined medical and prescription drug out-of-pocket maximum if you participate in the HDHP with HSA plan).

35. PREVENTIVE CARE/WELLNESS BENEFIT

As described in the Schedule of Benefits, the Plan will pay 100% of the Reasonable and Customary Charge for certain routine preventive services, in and out-of-network, except routine, preventive colonoscopies, which will only be covered at 100% in-network and otherwise will be covered at the out-of-network benefit level. This means that these services (other than out-of-network preventive colonoscopies) will not be subject to any deductible and you will not have to pay any cost sharing. Generally, this applies to routine physical examinations/office visits (including “well woman” visits), routine lab testing and radiology services, immunizations, and birth control devices, including any costs for insertion, removal, or fitting if prescribed by a Physician, and lactation support, counseling and equipment, as well as any other services as required under the health care reform law (the Affordable Care Act). The preventive services covered by the Plan include the following:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF) (but in the case of colorectal cancer screenings, the Plan has expanded coverage to start at age 45);
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

To find out if a particular preventive service will be paid at 100%, contact the Claims Processor, or see the list of preventive services, including women's preventive services, located at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> and www.pdrma.org.

36. PRIVATE DUTY NURSING

Services certified as Medically Necessary by a Physician and provided by a nurse. The nursing services provided must require the special skill and training of a Registered Nurse, Licensed Practical Nurse or Professional Nurse.

37. PROSTHETIC APPLIANCES AND DEVICES

The initial purchase of Prosthetic Appliances and/or Devices. Replacement or repair of Prosthetic Appliances and/or Devices when Medically Necessary due to physiological change to the patient, due

to normal wear and tear of the item or where the existing equipment is damaged and cannot be made serviceable.

38. RADIATION THERAPY

Radiation therapy by X-ray, radon, radium and radioactive isotopes

39. REHABILITATION FACILITY

Facility charges for rehabilitation treatment performed in a Rehabilitation Facility and associated services and supplies.

40. SKILLED NURSING FACILITY

a) Services

Services and supplies (other than personal items and professional services) provided while the patient is under continuous medical care and requires 24-hour nursing care, and room and board. Benefits are limited to the maximums stated in the Schedule of Benefits.

b) Requirements

Confinement must be ordered by the Physician as Medically Necessary.

The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the facility.

41. SMOKING CESSATION

Expenses relating to smoking cessation classes, programs or counseling to the extent required under the Affordable Care Act.

Benefits are also payable for FDA approved over-the-counter nicotine replacement therapy to the extent required under the Affordable Care Act and if prescribed by a Physician.

42. SPEECH THERAPY

Treatment by a Certified Speech Therapist to:

1. restore speech loss (sound output; motor sequence to make sound) or correct a voice disorder (vocal cord pathology) due to stroke, brain damage, Accident or Sickness; or
2. correct an impairment due to a congenital defect for which corrective surgery has been performed; or
3. treat pre-speech deficits and feeding disorders resulting from congenital developmental disorders, including treatment for oral-motor performance (trunk support, respiratory and phonatory control, jaw stability, tongue and lip posture) and sound development (vocalizing, babbling early words).

A professional evaluation will be required for item number three (3) above by a speech language pathologist who has a Certificate of Clinical Competence (C.C.C.) to confirm existence of a severity rating of moderate through profound.

Maintenance Care is not covered.

43. STERILIZATION

Procedures to bring about, but not reverse, sterilization, regardless of Medical Necessity.

44. SUBSTANCE ABUSE

Services and supplies to treat Substance Abuse will be covered on the same basis as services and supplies to treat any other Sickness.

45. SURGERY

a) Surgeon

Charges for multiple Surgical Procedures will be a covered expense subject to the following provisions:

- If bilateral or multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedure, plus 50% of the surgical allowance for each additional procedure performed through the same incision; as well as 50% of the surgical allowance for each additional procedure performed through a separate incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.
- If multiple unrelated Surgical Procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary percentage allowed for that procedure; and
- If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Reasonable and Customary allowance.

b) Anesthesiologist

Services of a qualified anesthesiologist (not the services of an operating surgeon or a surgical assistant) in administering regional or general anesthesia in connection with a covered surgical service. Usual related care rendered in connection with the administration of anesthesia is covered.

c) Cosmetic Surgery

Cosmetic surgery is covered if Medically Necessary for (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Sickness; or (c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect.

Additionally, this Plan shall provide, in a case of a Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- physical complications for all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage will be subject to annual deductibles, copayments, and coinsurance percentage provisions as are consistent with those established for other medical and surgical benefits under the Plan.

d) Dental Surgery

Dental services for the treatment of a fractured jaw or an Injury to sound natural teeth. Benefits are payable for the services of a Physician, Dentist or Dental Surgeon, provided the services are rendered for treatment of an Accidental Injury.

46. TELEMEDICINE

In order to meet Participants' needs for timely and affordable access to medical advice, the Plan offers a telemedicine program through Teladoc, whereby Participants may consult by telephone or online video conference or, in some cases, through a mobile application with board-certified Physicians 24 hours per day, 7 days per week. Telemedicine is appropriate for dealing with mild to moderate medical conditions such as skin concerns such as rashes, nasal congestion, the flu, urinary tract infections, pink eye, allergies, coughs, and ear infections or request for prescription refills. Use of this service may be especially helpful when a Participant is traveling on vacation or for business, prefers not to leave home with a sick child, or the Participant's regular Physician's office is closed.

Participants also may receive virtual primary care and annual check-ups through Teladoc's Primary 360 program. Primary 360 Physicians:

- are trained to treat and diagnose via phone/video,
- provide support to patients with issues such as weight, blood pressure, cholesterol, and diabetes management,
- perform basic mental health screenings,
- can prescribe medications and order routine labs and blood tests, and
- provide referrals to in-person specialists.

There will be no costs to Participants for a consultation with Teladoc for primary care or otherwise (except that Participants in the HDHP with HSA Plan must first meet the applicable deductible).

More information is available through Teladoc; see Important Phone Numbers/Contact Information above.

47. TEMPOROMANDIBULAR JOINT DYSFUNCTION

Covered services and supplies recognized as effective and appropriate by the medical or dental profession as necessary to treat TMJ, myofascial pain dysfunction syndromes and other associated disorders.

48. VISION CARE

Vision care is an optional benefit which is available to all Member Agencies. Check with the benefit coordinator to determine if your Employer has elected vision coverage and which level and type of coverage is offered.

Generally speaking, if the Member Agency has selected an "Allowance" vision care plan, benefits will be paid only up to the maximum allowances specified in the Schedule of Benefits (with the applicable maximum determined according to the specific plan selected).

On the other hand, if the Member Agency has selected a "Managed" vision care plan, care received in-network will be paid at 100% after payment of any applicable copayments, except that a maximum allowance applies with respect to frames and contacts that are not included in the Vision Claims Processor's exclusive collection. Additionally, non-network benefits are available under the Managed vision care plans subject to annual maximums.

If a Participant is eligible for vision care, benefits will be payable for the following services and supplies:

- Eye examinations, including refraction
- Lenses
- Frames
- Contact lenses

Coverage includes clear plastic single-vision, bifocal, trifocal, or lenticular lenses; polycarbonate lenses; high-index lenses; polarized lenses; progressive lenses; plastic photochromic lenses; scratch-resistant coating; premium scratch-resistant coating; tinting of plastic lenses, trivex lenses; glare-resistance, ultraviolet, anti-reflective and/or scratch-resistant coating; and blue light filtering. For more information, see the vision plan summary document applicable to the vision option selected by your Employer, which is available on the My Benefits Portal at www.pdrma.org.

J. Exclusions From Coverage

With the exception of those procedures authorized pursuant to Section IV. Care Management, C. Medical Case Management, the following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Allergy Immunotherapy. Injectable and non-injectable allergy immunotherapy is not covered under the prescription drug benefit but rather will be covered under the medical benefit, subject to the applicable deductibles, and out-of-pocket maximums and payable at the co-insurance rates set forth in the medical section of the Schedules of Benefits.

Charges which are not Medically Necessary.

Compound Drugs. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription.

Cosmetic or Reconstructive Surgery. Cosmetic or reconstructive surgery (including, but not limited to facial surgery and body contouring related to gender reassignment) unless expressly covered as set forth above regarding the description of benefits with respect to surgery or gender reassignment. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, Injury or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Charges for custodial care, including institutions that are custodial in nature such as homes for the aged, rest homes, and schools for the developmentally disabled.

Dental Treatment. Any dental treatment or services, except specified services and Medically Necessary Hospital expenses.

Drug Administration. Any charge for the administration of a prescription drug.

Drugs Requiring a Written Prescription (except those specified, injectable medications, those taken or administered in whole or in part during confinement in a licensed facility or those administered in a Physician's office) are not covered as a medical benefit under this Plan. However, they are covered as part of the prescription drug benefit under the plan, unless another exclusion applies. For questions, contact the *Pharmacy Benefit Manager* as identified on page 5.

Educational or Vocational Testing. Services for educational or vocational testing or training, except as specified and diabetic training.

Environmental ecological treatments.

Excluded Drugs. Certain drugs are not covered at all. For information on whether a drug is excluded, contact the Pharmacy Benefit Manager.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or Investigative Treatments, Drugs or Supplies. Any expenses for Experimental or Investigational treatment, drugs or supplies will be excluded from coverage by the Plan.

If a Plan Participant participates in an Approved Clinical Trial, the Plan will not deny or limit or impose additional conditions on coverage of routine patient costs for items and services furnished in connection with the trial merely because they are furnished as part of a trial. "Routine patient costs" for this purpose include items and services typically provided under the Plan for a Participant not enrolled in a clinical trial. The Plan will not deny coverage or impose additional conditions on coverage merely because a person receives these items or services as part of a trial. Also, the Plan will not discriminate against individuals for participating in a clinical trial. For example, the Plan will not deny coverage for side effects that a Participant develops as a result of participation in the trial, so long as these conditions otherwise would be covered. However, there is no coverage for: (1) the Experimental or Investigational item or service itself, (2) items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis, or (3) a service clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Eye Care. Glasses, contact lenses, or eye examinations and/or treatment (surgical or non-surgical) of refractive error for the correction of vision or fitting of glasses, except to the extent that your Employer has elected to offer vision benefits, you are enrolled in such benefits, and these services are included in such benefits. To determine whether your Employer offers vision benefits, please contact your Benefits Coordinator. If vision benefits are offered, you can learn more about the coverage available by reviewing the applicable vision plan summary document, which can be found on the My Benefits Portal at www.pdrma.org.

Felony Participation. Charges for a Sickness or Injury of the Participant resulting from or occurring during the Participant's commission, or attempted commission, of a criminal battery or felony. Claims shall be denied under this exclusion if the Plan Administrator has reason to believe, based on objective evidence, such as court records, police reports or medical records, that a criminal battery or felony was committed by the Participant. This exclusion will not apply to a Sickness or Injury sustained due to a medical condition (physical or mental) or domestic violence.

Foot Care. Treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Functional Therapy. Charges made for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision of this Plan.

Gender reassignment services. Gender reassignment services that alter the voice or contour the voice, such as laryngeal or tracheal procedures or speech therapy. (Such services may be covered for purposes other than gender reassignment, where Medical Necessity exists, such as in the case of Injury or Sickness.) Additionally, no benefits are available for surgery or related services to reverse the effects of previous gender reassignment surgery or related services. (Other gender reassignment services not specifically excluded may be covered as set forth in the description of benefits above.)

Government Coverage. Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a service-related Sickness or Injury.

Hair Loss. Care and treatment for hair loss including wigs, cranial prostheses, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

Hearing Aids and Exams. Charges for services or supplies in connection with hearing aids or exams not coordinated through EPIC Hearing Healthcare.

Hospital Employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnosis.

No Charge. Care or treatment for which there would not have been a charge if no coverage had been in force.

Non-Emergency Medical Condition Hospital Admissions. Care and treatment billed by a Hospital for an Emergency Room admission for a non-Emergency Medical Condition on a Friday or a Saturday. This does not apply if the admission is medically necessary and/or surgery is performed within 24 hours of admission.

No Obligation to Pay. Charges incurred for which the Participant has no legal obligation to pay.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Nutritional Supplements. Charges for nutritional and/or food supplements unless required to be covered by applicable law.

Occupational. Any treatment, service or drug to treat a Sickness or Injury that is covered by a Workers' Compensation Act or similar legislation.

Over-the-Counter Medications. Medications that are available over-the-counter (OTC), that do not require a prescription, unless required to be covered pursuant to the Affordable Care Act.

Personal Comfort Items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds.

Physician Visits. Charges made by a doctor for phone calls, video conferences, interviews, or other means of communication when the Physician does not see the patient in person for treatment, except as expressly set forth in the section of this plan entitled "Telemedicine" or as otherwise provided in the Plan or required by law. This also includes charges for failure to keep a scheduled visit or charges for completion of a claim form.

Reasonable and Customary. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Customary Charge.

Relationships. Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a spouse, Civil Union Partner, Domestic Partner, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement of Durable Medical Equipment. Replacement of lost or stolen Durable Medical Equipment, Orthotic Appliances and Devices, and Prosthetic Appliances and Devices, except as specified.

Respiratory Therapy Supplies. Charges for nebulizers and other respiratory therapy supplies are not covered under the prescription drug benefit but rather will be covered under the medical benefit, subject to the applicable deductibles, and out-of-pocket maximums and payable at the co-insurance rates applicable to “Durable Medical Equipment Expenses,” as set forth in the medical section of the Schedules of Benefits.

Sedative Action Electro Stimulation Therapy.

Services Before or After Coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sleep Therapy.

Sterilization Reversal.

Supply Limits. Drugs dispensed in excess of any supply limit (i.e., days supply or quantity limit) allowed by the Plan.

Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges or transplant-related travel defined as covered expenses.

Vitamins. Charges for vitamins, minerals, and/or supplements, unless required to be covered pursuant to the Affordable Care Act.

War. Any loss that is due to a declared or undeclared act of war.

Z therapy and transcendental meditation.

IV. CARE MANAGEMENT

A. Prior authorization for Hospital or Other Confinement

If a Participant requires Hospital or Other Confinement for an Injury or Sickness, it is recommended that the Participant obtain a clinical review and approval for the Hospital admission and length of stay from the Medical Care Management Organization at least one day prior to a non-emergency admission.

In the event of an admission for an Emergency Medical Condition or a pregnancy/maternity admission, authorization should be obtained within the next two business days or as soon as reasonably possible given the facts and circumstances of the emergency admission. Refer to the Plan identification card for the telephone number to call for prior authorization.

Full benefits for Hospital charges will be paid only for approved admissions and confinement days.

If confinement extends beyond the approved length of stay, additional days should be authorized by the Medical Care Management Organization. The same requirements will apply to the additional days.

Charges for any part of a Hospital Confinement not deemed to be Medically Necessary by the Medical Care Management Organization will be excluded. In-network providers are expressly required to obtain prior authorization. If prior authorization is not obtained by an in-network provider, the provider will be sanctioned based on the Claims Processor's contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

The Medical Care Management Organization does not verify, authorize or guarantee payment of benefits. The Medical Care Management Organization's authorization relates only to necessity of treatment. It is not a certification of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Plan. Benefit information can be obtained by contacting the Claims Processor. Benefit quotations do not guarantee payment of a claim.

Participants have the right to request information regarding the Plan's criteria for determining whether treatment is Medically Necessary from the Medical Care Management Organization.

B. Other Services Subject to Prior Authorization

It is also recommended that the Participant obtain prior authorization from the Medical Care Management Organization for the following services, devices or supplies at least two business days prior to receiving services. Refer to the Plan identification card for the telephone number to call for prior authorization. If you are unsure if you should obtain prior authorization for a procedure, medication, or equipment, please call the Medical Care Management Organization for verification.

- Air ambulance (other than with respect to an Emergency Medical Condition)
- Applied Behavior Analysis (ABA)
- Behavioral health (partial and intensive outpatient)
- Cardiac – certain procedures
- Procedures that might be considered cosmetic (including, but not limited to, breast related procedures, excess skin procedures).
- Deactivation of headache triggers
- Dialysis (in home, including medication)
- Durable Medical Equipment – some higher cost types (such as, but not limited to electric wheelchairs)
- Ear, nose or throat services such as bone conduction hearing aids, cochlear implants or nasal/sinus surgery
- Electrical stimulation of the brain, nerves, spinal cord or stomach
- Gastroenterology – some procedures (such as gastric electrical stimulation (GES))
- Gene therapy – some procedures
- Home health care including but not limited to a Coordinated Home Care Program or private duty nursing
- Home Hospice care
- Injectable medications
- Infusion therapy (including home infusion therapy)
- Lipid Apheresis
- Neurology – some procedures (such as deep brain stimulation and nerve neuromodulation/stimulation)
- Orthopedic / Musculoskeletal – certain procedures
- Pain management – certain procedures (such as occipital nerve stimulation)
- Private duty nursing
- Psychological or neuropsychological testing – some, but not all tests
- Sleep studies
- Surgeries of the face, mouth, jaw or teeth
- Transplant evaluations
- Wound care services such as high-pressure (hyperbaric) oxygen treatment

Prior authorization is recommended before services are rendered.

Charges for any services not determined to be Medically Necessary by the Medical Care Management Organization will be excluded. In-network providers are required to obtain prior authorization for the services listed above. If prior authorization is not obtained by the in-network provider, the provider will be sanctioned based on the Claims Processor's contractual agreement with the provider, and the Participant will be held harmless for the provider sanction.

Participants seeing an out-of-network provider should call the Medical Care Management Organization before receiving treatment (including, but not limited to, dialysis or any elective surgery) to determine if such treatment requires prior authorization or if the Plan considers the treatment to be Medically Necessary.

The Medical Care Management Organization does not verify, authorize or guarantee payment of benefits. The Medical Care Management Organization's authorization relates only to necessity of treatment. It is not a certification of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Plan. Benefit information can be obtained by contacting the Claims Processor. Benefit quotations do not guarantee payment of a claim.

Participants have the right to request information regarding the Plan's criteria for determining whether treatment is Medically Necessary from the Medical Care Management Organization.

See also discussion of Prior Authorization requirements regarding prescription drugs.

C. Medical Case Management

Case Management is a voluntary, collaborative process that assists you with the coordination of complex care services. A case manager also advocates for cost-effective interventions.

Complex care services may include treatment for a variety of diagnoses and treatments. The following are examples of situations in which a case manager may reach out to you to determine whether case management would be helpful:

- \$100,000 in claims paid, or expected to be paid.
- Multiple emergency room visits within a four-to-six month period.
- Recent hospital discharge with high risk of readmission.

The above list is not exhaustive; it merely offers examples.

When the case manager is notified of one of the above diagnoses (or any other diagnosis for which Medical Case Management might be appropriate), the case manager will consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Participant's condition changes, with the mutual agreement of the case manager, the patient, and the attending Physician.

The Plan, in consultation with the stop loss carrier, to the extent that a Participant has incurred expenses above the annual stop-loss attachment threshold, has the authority to authorize payment for services and supplies recommended by the treatment plan presented by the Medical Case Management Organization, whether or not the service is otherwise covered under the Plan. The stop loss carrier's decision to deny or approve a claim for stop loss insurance will not be determinative, but will be one factor considered by the Plan in rendering its decision.

Any services covered under this provision are specific to the individual case and shall under no circumstances set a precedent with respect to other similar claims. The Plan, in consultation with the stop loss carrier (as applicable), shall determine the appropriate benefit percentages and length of time for covering alternative treatments.

Notwithstanding anything herein to the contrary, among other outcomes of this process, the Plan, in consultation with the case manager and the stop loss carrier (if applicable), may, in its sole discretion, decide to cover out-of-network services on an in-network basis, particularly if comparable services are not available from an in-network provider.

Any deviation from the treatment plan without the case manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

V. EMPLOYEE ASSISTANCE PROGRAM

The PDRMA Health Program offers you and your family members access at no charge to an Employee Assistance Program offered through Ulliance, the Life Advisor EAP. This program provides confidential in-person, video, or telephonic short-term counseling with licensed mental health care professionals. Other services include coaching (regarding education, career advancement, financial, and other self-improvement goals), 24/7 crisis support, consultation regarding legal and financial issues, an identity theft program, materials regarding work/life balance, a well-being portal, and more. If you need long-term counseling, the Life Advisor EAP can help you find someone within your budget and in the Plan's provider network.

You can utilize this benefit throughout the year and are not limited to one use for any of the services. Services are totally free; there are no deductibles, co-payments or claim forms involved.

You may contact the EAP at the telephone number or through the website provided under Important Phone Numbers/Contact Information at the beginning of this document. For more information, see the Employee Assistance Program page of the PDRMA website or the My Benefits Portal at www.pdrma.org.

VI. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

A. Eligibility

The following are eligible:

1. EMPLOYEE

Employee eligibility for coverage under the Plan depends in part upon the personnel policies of the Member Agency for whom the Employee works. Generally speaking, a Member Agency may choose to apply one of the following three eligibility criteria to its Employees:

- (i) A Member Agency's Employee will be eligible if the Employee is employed by a Member Agency and regularly works 30 or more hours per week or a minimum of 1560 hours per year, and is considered a "benefits-eligible" employee as determined according to the relevant Member Agency's personnel policy,
- (ii) When a Member Agency defines "benefits-eligible" as working more than 30 hours per week, a Member Agency's Employee will be eligible if the Employee is employed by a Member Agency and regularly works the number of hours (or more) per week stated in the Member Agency's personnel policy to be considered "benefits-eligible," or
- (iii) A Member Agency's Employee will be eligible if employed by a Member Agency and considered "full-time" as defined under the "Employer Shared Responsibility" rules established by the Affordable Care Act ("ACA"). (Under this last option, a Member Agency may utilize the "Look-Back/Stability Period" method established under the ACA to determine that an Employee is "full-time" based on past service even if the person currently is not working 30 hours per week.)

Additionally, an Employee participating in the Illinois Municipal Retirement Fund (IMRF) or other similar pension plan who retires or becomes disabled as defined under the terms of IMRF or the other plan on or after January 1, 1991, and was covered under this Plan on the date immediately prior to retirement or disability, also will be eligible for Plan coverage.

2. DEPENDENTS

A Participant cannot be covered simultaneously as an Employee and a Dependent. Dependents include the following:

a.) Spouse

The Employee's spouse who is not legally divorced from the Employee.

b.) Civil Union Partner

The Employee's Civil Union Partner whose union to the Employee has not been legally terminated. Civil unions or similar unions obtained outside the state of Illinois will be recognized.

c.) Eligible Domestic Partner

Subject to the Member Agency's personnel policies and the Member Agency's election to extend benefits, an Employee's Domestic Partner may be eligible for coverage. In addition to the Employer electing to provide benefits, the following qualifications must be met:

Domestic Partners are persons who at the time of enrollment in the PDRMA Health Program:

- Are at least eighteen (18) years of age or older;
- Are each competent to enter into a contract;
- Are not legally married to any person and are not related by blood to each other to a degree that would prohibit legal marriage;
- Are each other's sole Domestic Partner;
- Intend to remain together indefinitely;
- Share a permanent residence;
- Agree to file a Termination of Domestic Partner Relationship form within thirty (30) days if any of the above facts or other conditions to qualify for coverage change;
- Execute an Affidavit, indicating compliance of the persons executing such Affidavit with all the requirements for a Domestic Partner Relationship set forth in the Agency's policy;
- For a minimum of twelve (12) months, at least three (3) of the following have existed for this Domestic Partner relationship, and now exist:
 1. Municipal or other form of Domestic Partner relationship agreement, certification or registration.
 2. Joint liability under mortgage or lease.
 3. Designation of the Domestic Partner as beneficiary for the Employee's life insurance, IMRF or other retirement benefits, or an individual retirement account.
 4. Designation of Domestic Partner as primary beneficiary under the Employee's will.
 5. Holder of durable health care and/or property powers of attorney.
 6. Joint ownership of a motor vehicle.
 7. Joint checking, bank or credit account, or investment.
 8. Payment of shared household expenses.
 9. Other substantial documentation of the Domestic Partner relationship.

An Affidavit by which both the Employee and Domestic Partner confirm their Domestic Partner relationship will be required for coverage under the PDRMA Health Program, together with documentation confirming the existence of the above items used to qualify. Documentation should clearly indicate the relationship has been in existence for a minimum of one year (e.g. joint bank statement from a year ago and one from current month).

d.) Children

An Employee's child from birth until the last day of the month in which the child attains age 26.

An Employee's child who was covered under the Plan prior to attaining age 26 (or who was continuously covered prior to attaining age 26 under another group health plan in which the Employee was participating immediately prior to becoming eligible for coverage under this Plan provided that the Employee enrolls such child in this Plan as soon as the Employee becomes eligible for coverage) and who is 26 years of age or older, and who, from the date such child's coverage would otherwise terminate

under the Plan (or another group health plan) due to the attainment of age 26, is both (a) incapable of engaging 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 can be expected to last for a continuous period of not less than twelve months and (b) dependent upon the Employee for more than one-half of such child's financial support and maintenance. (Proof may be required.)

The Employer will have the right to require due proof of the continuation of the mental and/or physical impairment and will have the right and opportunity to examine the child whenever the Employer may reasonably require it during such continuation. After two years have elapsed from the date the child attained the limiting age, only one examination will be required per year.

An Employee's child who is a military veteran and who is at least 26 years of age and under 30 and is (a) unmarried and (b) an Illinois resident. (Proof may be required). To be considered a "military veteran" the child must have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States and must have received a release or discharge, other than a dishonorable discharge.

A "Child" is:

- An Employee's natural born child or legally adopted child. An adopted child shall be considered a "child" from the moment the child is placed in the custody of the parents for adoption; or
- An Employee's stepchild or the Civil Union Partner's natural born or legally adopted child; or
- Any child for whom the Employee, the Employee's Civil Union Partner, or the Employee's Domestic Partner has been granted legal guardianship by a court of law or agency with appropriate jurisdiction for so long as such guardianship remains in effect; or
- Any child for whom the Employee is required to provide health care coverage under a Qualified Medical Child Support Order or National Medical Support Notice. Participants have the right to obtain applicable determination procedures free of charge from the Plan Administrator; or
- A covered Domestic Partner's child who lives with the Domestic Partner and is a biological or adopted child of a Domestic Partner.

If both parents of a child are covered for benefits, either but not both may cover the child as a Dependent.

B. Enrollment and Effective Dates

When an Employee enrolls the Employee's Dependents and authorizes any required contributions for Dependent benefits, Dependent benefits will become effective as follows:

- If an Employee has eligible Dependents on the effective date of coverage and has enrolled for dependent benefits on or prior to the Employee's effective date, then coverage for those Dependents will be effective on the date the Employee's coverage begins.
- If an Employee does not have eligible Dependents on the effective date of coverage and later acquires an eligible Dependent(s), and if such Employee enrolls for Dependent benefits within 31 days of the date of acquisition, then coverage for the Dependent(s) will be effective on the date of acquisition.

If the Employee is already enrolled for Dependent benefits, any newly acquired Dependents, including newborns, must be enrolled within 31 days of acquisition. Coverage will be effective on the date of acquisition.

Benefits will not become effective for the Dependents of an Employee unless the Employee is covered, or simultaneously becomes covered, for benefits. Under no circumstances will coverage for an Employee's Dependents occur prior to coverage for the Employee.

If an Employee does not enroll the Employee and any Dependents within 31 days of the date eligible, they will not be eligible to enroll in the Plan until the Annual Open Enrollment Period or a Special Enrollment Period.

1. NEW HIRE ENROLLMENT

An Employee hired on or after the effective date of this Plan becomes eligible for benefits after satisfying any applicable Waiting Period required by the Member Agency, provided that such Waiting Period may not exceed 90 calendar days from (1) the Employee's date of hire, (2) a bona fide orientation period (sometimes also referred to as a probationary period or trial period) of no more than one month, or (3) the Employee's satisfaction of the Member Agency's eligibility requirements specific to the job (such as licensing or training). (Note, however, that a Member Agency may not impose an eligibility requirement that is related solely to the passage of time (beyond the permitted one-month orientation period), as doing so would effectively impermissibly extend the Waiting Period.) However, in the case of an Employee who is considered to be a new "variable hour employee" as defined under the Affordable Care Act, coverage will begin no later than the first of the month after such Employee completes 13 months of employment.

Coverage for benefits becomes effective on the date the Employee is eligible for coverage provided the Employee has enrolled within 31 days of the date eligible.

Notwithstanding the preceding, an Employee previously employed by a Member Agency and covered by this Plan as of the date of termination of employment with that Member Agency will be eligible for benefits immediately without having to satisfy another waiting period if the Employee is employed by another Member Agency within 31 days.

Each Employee becomes eligible to cover Dependents for benefits on the later of the following dates:

- the date the Employee is eligible for benefits, if the Employee then has a Dependent;
- the date the Employee first acquires an eligible Dependent through marriage, civil union, birth, adoption, placement for adoption, legal guardianship, or meeting the Domestic Partner relationship requirements.

If an Employee does not enroll the Employee or the Employee and any Dependents within 31 days of the date eligible, they will not be eligible to enroll in the Plan until the Annual Open Enrollment Period or a Special Enrollment Period.

2. ANNUAL OPEN ENROLLMENT

If the Employee enrolls during the annual Open Enrollment period held as determined by the Plan Administrator, coverage will be effective on the subsequent January 1st.

3. SPECIAL ENROLLMENT: LOSS OF OTHER COVERAGE/NEW DEPENDENT

If an Employee experiences a loss of other health coverage, including COBRA Continuation Coverage, the existence of which was the reason for declining coverage under this Plan when first eligible to enroll, then the Employee may enroll for coverage within 31 days of the loss of such coverage. Loss of coverage means that COBRA Continuation Coverage has been exhausted or that coverage which was not under a COBRA Continuation provision has been terminated as a result of a loss of eligibility for the coverage or termination of employer contributions towards such coverage. Coverage will be effective on the date of the occurrence.

If an Employee declined coverage for any Dependents under this Plan when first eligible to enroll because such Dependents had other health coverage, including COBRA Continuation Coverage, and they experience a loss of the other health coverage as described above, the Employee may enroll for Dependent benefits within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If an Employee acquires a Dependent through marriage, civil union or domestic partnership, the Employee may enroll for coverage within 31 days of the marriage, civil union or of the date that the requirements outlined for recognition of the domestic partnership are met. Coverage will be effective on the date of the marriage, civil union or the date the Domestic Partner requirements have been met.

If an Employee acquires a Dependent through birth, adoption or placement for adoption, the Employee may enroll for coverage within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

If an Employee or the Employee's Dependents lost other coverage as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), then a special enrollment right will not exist.

4. SPECIAL ENROLLMENT: MEDICAID OR SCHIP LOSS OF ELIGIBILITY/ELIGIBILITY TO PARTICIPATE IN MEDICAID OR SCHIP PREMIUM ASSISTANCE

If the Employee or a Dependent experience (1) a loss of eligibility for Medicaid or a state children's health insurance program (SCHIP), or (2) become eligible to participate in a premium assistance

program under Medicaid or SCHIP, the Employee and/or the Employee's Dependent will be entitled to receive coverage under the Plan. Such enrollment must be requested within 60 days of the loss of such eligibility or becoming eligible for such premium assistance.

If an Employee or the Employee's Dependents lost other coverage as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), then a special enrollment right will not exist.

5. SPECIAL DISENROLLMENT: DEPENDENT GAINS OTHER COVERAGE THROUGH EMPLOYMENT

An Employee may drop coverage mid-year (meaning other than at annual Open Enrollment) for the Employee and/or the Employee's Dependents if such Employee and/or such Dependents become eligible for and enroll in coverage under another group health plan due to the commencement of employment of a Dependent. A request for such a change must be made within 31 days of enrollment in the other group health plan, and this Plan may request proof of such enrollment.

C. No Preexisting Conditions Exclusions

The Plan does not restrict coverage based on the existence of preexisting conditions.

D. Eligibility Claims and Appeals Procedures

This section only pertains to claims and issues involving eligibility under the Plan. All other claims and appeal procedures under the Plan (excluding eligibility issues) are described in Sections VIII and IX.

The Participant may provide the Plan Administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a Participant and consent to the release of information related to the covered person to the authorized representative with respect to a claim for eligibility or an appeal. Authorization forms may be obtained on the PDRMA Health Program website or requested from the Plan Administrator or Agency Benefit Coordinator.

The following table summarizes the steps in the eligibility claims and appeals procedures. Additional details are provided in items 1 through 5 below.

	Who processes the claim or appeal:	Response Issued Within:	If Participant disagrees, may take next step, but must do so within:
Eligibility Claims (or a request to	PDRMA Health	30 calendar days	180 calendar days

enroll in the plan)			
First Appeal of Eligibility Claim	Health Program Director at PDRMA	30 calendar days	60 calendar days
Second Appeal of Eligibility Claim	PDRMA Health Benefits Committee	30 calendar days	30 calendar days
Third and Final Appeal of Eligibility Claim	PDRMA Board of Directors	30 calendar days	Not Applicable
First Appeal of Urgent Care Eligibility Claims	Health Program Director at PDRMA	10 calendar days	60 calendar days

1. ELIGIBILITY CLAIMS

Claims involving eligibility should be submitted in writing to the Plan Administrator. The Plan Administrator will complete its determination regarding eligibility within thirty (30) calendar days of receipt of the claim or enrollment materials. A fifteen (15) day extension is available to the Plan Administrator if needed due to circumstances beyond the control of the Plan.

After an eligibility claim has been submitted, the Plan Administrator will provide the Participant's Benefits Coordinator with a notice detailing the additional information needed, if any is needed for determination of the claim. The notice will be provided within the initial thirty (30) calendar days of receipt of the claim and will state the date as of which the Plan expects to make a decision. The Participant will have forty-five (45) calendar days from the receipt of the request to provide the information. Failure to respond in a timely and complete manner may result in a denial of enrollment.

2. FIRST APPEAL OF ELIGIBILITY CLAIMS

If the Participant is dissatisfied with an eligibility determination made by the Plan Administrator, an appeal may be made in writing to the Health Program Director at 2033 Burlington Avenue, Lisle, IL 60532 within one hundred eighty (180) calendar days of the initial Notice of Denial.

The following describes the review process and rights of the Participant:

- a. The Participant has the right to submit documents, information and comments and to present evidence and testimony.
- b. The Participant has the right to access, free of charge, relevant information to the claim.
- c. Before a final determination on appeal is rendered, the Participant will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim.
- d. The review takes into account all information submitted by the Participant, even if it was not considered in the initial eligibility determination.
- e. The review by the Health Program Director will not give any weight to the reasoning of the original denial, but may use information gathered as part of the original analysis.

The Health Program Director will provide the Participant with a written Notice of Appeal Decision within thirty (30) calendar days of receipt of the written request for the appeal.

3. SECOND APPEAL OF ELIGIBILITY CLAIMS

The Participant may appeal the decision of the Health Program Director by filing a written appeal with the Health Benefits Committee in care of the President/Chief Executive Officer at 2033 Burlington Avenue, Lisle, IL 60532 within sixty (60) calendar days of the Notice of Appeal Decision.

The review process of the second appeal will be essentially the same as the first appeal review process above. The review by the Health Benefits Committee will not give any weight to the reasoning of the original denial, but may use information gathered as part of the original analysis or the Health Program Director's analysis. The Participant may ask that a hearing be held, such request may be granted at the discretion of the Health Benefits Committee. The Participant will have full opportunity to present the Participant's position, and, at the sole discretion of the Health Benefits Committee, may be permitted to be represented by legal counsel at such presentation. However, the Participant will be responsible for the Participant's own legal counsel's fees, as well as any costs related to any witnesses the Participant calls to testify.

The Health Benefits Committee will render its decision in writing to the Participant postmarked within ten (10) business days after any hearing held before it or if no hearing is held, postmarked no later than thirty (30) days after the postmark of the Participant's request for review.

4. THIRD AND FINAL APPEAL OF ELIGIBILITY CLAIMS

External review is not available for eligibility claims; however, the Plan offers the following voluntary third and final appeal process to Participants for claims related to eligibility issues. The Plan makes a voluntary third level of appeal available so Participants can further pursue resolution of their issue within the Plan.

A Participant must have exhausted the appeal process set forth in Section V. D. above before filing an appeal under this voluntary final appeal process. Unless otherwise set forth below, there is no cost to the Participant under this voluntary final appeal process.

The Participant may appeal the Health Benefits Committee's decision to the PDRMA Board of Directors. Such request must be in writing and addressed to the Chairman of the Board of Directors at PDRMA, 2033 Burlington Avenue, Lisle, IL 60532 and postmarked within thirty (30) days of the postmarked Notice of Appeal Decision by which the Participant was notified of the Health Benefits Committee's decision. The Board of Directors will consider such requests within thirty (30) days of the postmark of the request. The Participant may ask that a hearing be held, such request may be granted at the discretion of the Board of Directors. The Participant will have a full opportunity to present the Participant's position, and, at the sole discretion of the Board of Directors, may be permitted to be represented by legal counsel at such presentation. However, the Participant will be responsible for the Participant's own legal counsel's fees, as well as any costs related to any witnesses the Participant calls to testify. The Board of Directors will render its decision in writing to the Participant postmarked within ten (10) business days after any hearing held before it or if no hearing is held, postmarked no later than thirty (30) days after the postmark of the Participant's request for review.

The decision of the PDRMA Board of Directors will be final.

NOTE: The decision of a Participant as to whether to submit a benefit dispute to the voluntary appeal process will have no effect on the Participant's rights to any other benefits under the Plan.

A Participant who requests an appeal under the voluntary third appeal process may request information to assist in the Participant's decision to submit a benefit dispute to the voluntary third appeal process, including information related to the Participant's right to representation, the process for selecting the decision maker(s), and the circumstances, if any, that may affect the impartiality of the decision maker(s), such as any financial or personal interests in the result or any past or present relationship with any party to the voluntary appeal process.

5. URGENT CARE ELIGIBILITY CLAIMS

If a First Appeal of Eligibility Claim involves urgent care:

- a. The request will be ruled upon and the Participant (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than ten (10) calendar days after the request was received; or
- b. If additional information is required, the Participant will be notified. Following a timely response, the Participant will be notified as soon as possible but no later than six (6) calendar days after receipt of additional information. Failure to timely submit requested information may result in a denial of the claim.

Appeals of any urgent care eligibility claims will be processed in the same manner as set forth in Section V. D. 2. above. However, urgent care eligibility claims will be decided by the Health Program Director within ten (10) calendar days of receipt of the first appeal from the Participant.

If the Participant is dissatisfied with the Health Program Director's decision, a voluntary second appeal may be filed with the Health Benefits Committee under the process and timeframes stated in section V. D. 3. above.

If the Participant is dissatisfied with the Health Benefits Committee's decision, a voluntary third appeal may be filed with the Board of Directors under the process and timeframes stated in section V. D. 4. above.

A Participant must have exhausted the appeal process to the Health Program Director set forth in Section V. D. 2. Above before filing an appeal under the voluntary appeal process. Unless otherwise set forth above, there is no cost to the Participant under these voluntary appeal processes. External review is not available for urgent care eligibility claims.

VII. EXTENSIONS OF COVERAGE

A. FMLA Qualified Leave of Absence

Note: The following coverage, or comparable coverage voluntarily provided by the Plan, is extended as applicable to all Participants, including Domestic Partners and their children.

If the covered Employee takes a qualified leave of absence as recognized by the Family and Medical Leave Act of 1993, as amended or similar state law, coverage for the Employee and any covered Dependents may be continued for the duration of the qualified leave up to twelve weeks (twenty-six weeks under certain circumstances) under the Family and Medical Leave Act of 1993.

B. Other Leave of Absence

If the covered Employee takes an approved leave of absence, coverage for the Employee and any covered Dependents may be continued for a maximum of 12 months to run concurrently with the Family and Medical Leave Act of 1993 extension of coverage. The length of continuation during a leave of absence (other than a leave of absence pursuant to the Family and Medical Leave Act) is determined according to the policy of the Member Agency for which the Employee works, but may not exceed 12 months as indicated above. Following the expiration of any such extension of coverage, continuation coverage under COBRA will be offered.

C. IMRF or Similar Pension Plan Continuation Coverage

A non-Medicare eligible Employee who is eligible for a pension from the Illinois Municipal Retirement Fund (IMRF), or with respect to employees of a Member Agency whose employees do not participate in IMRF, the pension plan of the Member Agency ("similar pension plan") at the time of retirement through normal procedures or through ERI (Early Retirement Incentive), an Employee who is eligible for disability benefits under IMRF or a similar pension plan, or in some instances the surviving spouse or Civil Union Partner of a retired or disabled Employee, may elect to continue the group health benefits provided under this Plan as detailed below. Typically, the individual will be required to pay the full cost of coverage (including both the Employee and Employer share of the cost); however, in some cases, the Employer may continue to bear a portion of the cost.

IMRF or similar pension plan Continuation Coverage will end (based on the classification as a retiree, disabled member or surviving spouse/Civil Union Partner) as follows:

1. RETIREES

If the Employee is a retiree, coverage will end when the first of the following events occur:

- The retiree returns to active service in IMRF/pension-covered employment.
- UThe retiree is convicted of an IMRF job related felony.
- The retiree dies.
- The retiree becomes eligible for Medicare. (Notwithstanding the preceding, the non-Medicare eligible covered spouse, Civil Union Spouse, or Domestic Partner of a retiree will be able to

continue coverage beyond the date the retiree becomes eligible for Medicare until such spouse or partner becomes eligible for Medicare.)

- The date the retiree fails to pay premium.
- The date the Employer ceases to provide any group health plan to Employees.

2. DISABLED EMPLOYEE

If the Employee is disabled, coverage will end when the first of the following events occur:

- The disabled member returns to active service in IMRF/pension-covered employment.
- The disabled member is convicted of an IMRF job related felony.
- The disabled member dies.
- The disabled member turns 65. (Notwithstanding the preceding, the non-Medicare eligible covered spouse, Civil Union Partner, or Domestic Partner of a disabled member will be able to continue coverage beyond the date the disabled member turns 65 until such spouse or partner becomes eligible for Medicare.)
- The disabled member exercises a refund option or accepts a separation benefit under the Illinois Pension Code.
- The date the disabled member fails to pay premium.
- The date the Employer ceases to provide any group health plan to Employees.

3. SURVIVING SPOUSES

If the Participant is a Surviving Spouse or surviving Civil Union Partner of a covered retiree or disabled Employee and is receiving a Surviving Spouse pension, coverage will end when the first of the following events occur:

- The date the Surviving Spouse or Civil Union Partner becomes eligible for Medicare.
- The date the Surviving Spouse or Civil Union Partner dies.
- The date the Surviving Spouse or Civil Union Partner fails to pay premium.
- The date the Employer ceases to provide any group health plan to active Employees.
- The date the Surviving Spouse or Civil Union Partner no longer receives Surviving Spouse pension benefits.

4. DEPENDENTS

Dependent coverage may only be continued if the Employee's coverage is continued except in the instance of a Surviving Spouse or surviving Civil Union Partner who has an independent right to continue. Dependents coverage generally ends on the same date the Employee's coverage ends (except for a Surviving Spouse) as described above. However, as noted above, a non-Medicare eligible spouse, Civil Union Partner, or Domestic Partner may continue coverage beyond the date a retiree loses coverage due to Medicare eligibility or a disabled member loses coverage due to turning age 65 until such spouse or partner becomes eligible for Medicare. Coverage will be continued only for those Participants that were covered under the Plan on the day immediately preceding the retirement.

D. COBRA Continuation Coverage

Note: The following coverage, or comparable coverage voluntarily provided by the Plan, is extended as applicable to all Participants, including Civil Union Partners, Domestic Partners and their children.

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA) requires that an Employee and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided they pay the full cost of Plan coverage, not to exceed 102% of the total cost (Employer and Employee) or 150% of the total cost during the 11-month extension for disability.

Each Qualified Beneficiary, including the Employee, spouse or any Dependent covered under the regular Plan, may make an independent election for Continuation coverage.

Coverage may be continued up to 18 months for an Employee and/or Dependent in the qualifying event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of an Employee. Continuation coverage may be extended from 18 months to 36 months for Dependent(s) who are qualified beneficiaries if during the 18-month period a second qualifying event occurs, such as the Employee dies, enrolls in Medicare, or divorces a spouse or dissolves a Civil Union Partnership, or terminates a domestic partnership. This extension may also apply upon the loss of Dependent status by a Dependent child. However, the extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Continuation coverage may extend from 18 months to 29 months for an Employee and/or Dependent who is or becomes totally disabled (as determined by the Social Security Administration under Title 2 or Title 16) at any time during the first 60 days of COBRA continuation coverage, provided that such Employee and/or Dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months. If during the continuation coverage the qualified beneficiary is later determined by the SSA to be no longer disabled, the individual must inform the Plan of this redetermination within 30 days of the date it is made.

Coverage may be continued for up to 36 months for a Dependent in the qualifying event of:

- (a) The death of the Employee;
- (b) The divorce of the Employee from a spouse or dissolution of the Employee's Civil Union;
- (c) The termination of a Domestic Partner relationship;
- (d) The Employee's becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the Plan by the Employee and the Employee's Dependents;
- (e) The loss of Dependent status by a Dependent child under the terms of this Plan.

Any period of extended coverage a Participant is entitled to pursuant to the provisions of Section VI. F below, USERRA, and/or COBRA will run concurrently and not consecutively.

Coverage will be continued only for those Employees and/or Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born or placed for adoption with the Participant during the period of COBRA continuation coverage, such child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

- (a) The date ending the period for which any required contribution has been paid;
- (b) The date the Employee and/or Dependent first become entitled to Medicare, or first becomes covered under another group health plan;
- (c) The date the Employer ceases to provide any group health plan.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Member Agencies, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee is a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, Civil Union Partner, Domestic Partner, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is hereby automatically changed to comply with the law.

Note: All Plan Participants must notify the Plan in writing within sixty (60) days of:

- (a) Divorce or dissolution of a Civil Union
- (b) Termination of a Domestic Partner relationship
- (c) Covered Dependent child ceasing to qualify as a Dependent
- (d) Acceptance of Medicare or coverage under another employer's group health plan (whether or not as an Employee).
- (e) Second qualifying event
- (f) Qualified Beneficiary's disability
- (g) Death of the Employee
- (h) Qualified Beneficiary's cessation of disability (Note: all Plan Participants must notify the Plan in writing within thirty (30) days of cessation of disability)

Written notice must be provided to Plan Sponsor. The notice must include the name of the Employee with identification number, Plan Name and Number, date and type of the qualifying event and name(s) of the applicable Dependent(s).

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

1. NOTIFICATION RESPONSIBILITIES

Under the law, the Employee or a Family member is responsible to notify the PDRMA Health Program, the Plan Administrator, of a divorce, or loss of Dependent status (as defined in the Plan Document) within 60 days of whichever is later: the date of the event or the date coverage will be lost because of the event. Likewise, the PDRMA Health Program requires the employee or a Family member to notify the Program of dissolution of a civil union or termination of a domestic partner relationship within 60 days of the later of the date of the event or the date coverage will be lost because of the event. If this

notification is not completed in a timely manner, then rights to continuation of coverage will be forfeited. Please check with the Employer's benefit coordinator for the notification procedure.

The Employee is also responsible to notify the Plan Administrator or the Employer of any address changes. All correspondence concerning COBRA will be mailed to the last known address. Failure to notify of an address change may delay notifications and possibly forfeit the right to continuation coverage.

2. ELECTION PERIOD

Complete instructions on COBRA, including a quote and the election form will be provided to Qualified Beneficiaries upon notification of the occurrence of a Qualifying Event. Under COBRA, Qualified Beneficiaries have 60 days from the later of (i) the date coverage was lost due to a Qualifying Event or (ii) the date notification of rights to continuation coverage is sent to inform the Plan Administrator of election for continuation coverage. Each Qualified Beneficiary has individual independent election rights under COBRA. If a Qualified Beneficiary waives the continuation coverage, the waiver can be revoked at any time before the end of the election period. An election can be made on behalf of the Qualified Beneficiary by a third party. If continuation coverage is not elected within the election period, rights to continuation coverage will end, and no coverage will be provided as of the Qualifying Event.

3. BENEFITS

Qualified Beneficiaries are entitled to coverage that is identical to coverage provided under the Plan to similarly situated active Employees. Qualified Beneficiaries do not have to show evidence of insurability to elect continuation coverage. However, continuation coverage under the law is provided subject to eligibility for coverage under the Plan. The PDRMA Health Program reserves the right to terminate continuation coverage retroactively to the Qualifying Event if the Qualified Beneficiary is determined to be ineligible.

4. PREMIUMS AND PAYMENT GRACE PERIODS

Qualified Beneficiaries are responsible for paying the entire applicable premium, however, anyone may make payment on behalf of a Qualified Beneficiary. The Plan may impose up to an additional 2% administration charge for continuation coverage. In addition, during an 11-month disability extension, the Plan may charge a premium equal to 150% of the cost of coverage under the group health plan.

The PDRMA Health Program will include monthly premium rates and payment due dates in the COBRA election notice that it provides to Qualified Beneficiaries upon receipt of notice of a Qualifying Event. COBRA law provides an initial grace period of 45 days from the date of election in which to make the first premium payment. This first payment must include all applicable retroactive premiums. Failure to make the first premium payment on a timely basis will cause coverage to terminate, even though elected, retroactive to the Qualifying Event. Further regularly scheduled monthly premium payments (other payment intervals such as weekly, quarterly or semi-annually are permissible) must be received by PDRMA postmarked within 30 days of the due date.

Failure to make timely payments results in a forfeiture of coverage. If coverage is forfeited, it will terminate retroactive to the end of the last period for which payment was timely received. If a check is received in a timely manner, and subsequently is returned "NSF" non-sufficient funds, the PDRMA Plan Administrator will allow the individual 10 calendar days to make payment by money order or cashier's check. This payment must include the regular premium amount, plus the bank's NSF fee. PDRMA will

require that all further payments be made by money order or cashier's check; personal checks will no longer be accepted.

5. ALTERNATIVES TO COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace created pursuant to the Affordable Care Act. In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. 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 (or mid-year) enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

E. Uniformed Services Employment and Reemployment Rights Act (USERRA) and Illinois Service Member Employment and Reemployment Rights Act (ISERRA)

Under USERRA and ISERRA (the "Acts") if a Participant is absent from employment by reason of military service as defined in the respective Acts, the Plan will allow that person to continue such coverage for a certain period of time. An Employee who goes on unpaid military leave of absence may continue to participate in this Plan during the military leave until the earlier of:

- The 24-month period beginning on the date on which the Employee's absence begins; or
- The period ending on the day after the date on which the Employee fails to apply for or return to a position of employment with the Employer, as determined in accordance with the applicable law.

Any period of extended coverage a Participant is entitled to pursuant to the provisions of USERRA, ISERRA, and/or COBRA will run concurrently and not consecutively.

Under USERRA, continuation coverage during military leave generally must be elected within the 60-day period following the Employee's loss of coverage under the Employer's group health plan due to entry in to military service, and the Employee may be required by the Employer to pay the full cost of coverage during the leave plus a 2% administrative surcharge unless the leave is less than 31 days, in which case, the Employee need only pay the Employee contribution. Under ISERRA, in the case of employers that are, among others, units of local government (such as park districts), the Employee may be required to continue to pay only the Employee contribution for the duration of the leave.

Failure to make timely payments may result in a termination of coverage. If coverage is terminated, it will terminate retroactive to the end of the last period for which payment was timely received.

Unlike COBRA, neither USERRA nor ISERRA requires an election notice, or any other type of notice, advising the Employee of the Employee's rights. Therefore, it is incumbent upon the Employee to

provide notice to the Employee's Employer and/or the Plan Administrator of the Employee's intention to take a leave under USERRA or ISERRA.

If the Employee becomes reemployed by their previous Employer, then the coverage will be effective without the application of a Waiting Period (though no coverage is provided for service-related illnesses or injuries) for the Employee and any Dependents.

VIII. TERMINATION AND REINSTATEMENT OF COVERAGE

A. Termination of Employee Coverage

The coverage of any Employee covered under this Plan will cease on the earliest of the following dates except as provided under the section regarding Extensions of Coverage (if applicable):

- The date this Plan terminates.
- The date ending the period for which any required contributions have been paid.
- The date the Employee is no longer eligible for coverage under the Employee's Plan.
- The date determined by the Plan due to an act of fraud or material misrepresentation committed by the Employee or the Employee's Dependent.
- The date the Employee begins active duty in the Armed Forces of any country for longer than two weeks, except as specified in Section VI. Extensions of Coverage.
- The date of death.
- The date the Employee's employment terminates.
- The date the Employee elects in writing that termination of coverage occurs as long as the request is made within the appropriate timeframe of the event that allows for the change (see sections Annual Open Enrollment and Special Enrollments).

B. Termination of Dependent Coverage

Coverage with respect to each Dependent covered under this Plan will cease on the earliest of the following dates:

- The date benefits cease for the Employee.
- The date such individual ceases to be a Dependent as defined in this Plan.
- The date determined by the Plan due to an act of fraud or material misrepresentation committed by the Employee or the Dependent.
- The date the employee's dependent spouse, Civil Union Partner, or Domestic Partner begins active duty in the Armed Forces of any country for longer than two weeks.
- The date for which written election of termination is received as long as the request is made within the appropriate timeframe of the event that allows for the change (see sections Annual Open Enrollment and Special Enrollments).
- The date ending the period for which any required contributions have been paid.

C. Reinstatement of Participant's Coverage

1. COBRA PARTICIPANTS

A Qualified Beneficiary who has elected COBRA continuation coverage will be considered to have had no lapse of coverage, provided the coverage is in effect on the day before the Employee returns to eligible employment.

2. REINSTATEMENT OF COVERAGE FOLLOWING A MILITARY LEAVE

Upon return from a military leave of absence, provided the Employee qualifies under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and provided that an enrollment form is submitted, coverage for the Employee and eligible Dependents will be reinstated on the return-to-work date. Under these conditions, the Employee and any eligible Dependents will not be subject to a Waiting Period. Any deductible or out-of-pocket maximum satisfied prior to the leave of absence will be credited if reinstatement takes place during the same Calendar Year in which the expenses were incurred.

D. Fraud or Material Misrepresentation

If any Participant deliberately defrauds or misleads the Member Agency or the Plan Administrator about the eligibility or entitlement to benefits of the Employee or the Employee's Dependents, the Plan Administrator has the right to terminate Plan coverage for that Employee and/or any of the Employee's covered Dependents immediately and retroactively. The Plan shall provide thirty (30) days advance written notice of a retroactive termination of coverage due to fraud or material misrepresentation. The Plan shall be entitled to recover (including by means of offset against future benefits) from the Employee and/or the Employee's covered Dependents any claims mistakenly paid due to mistake, fraud or a wrongful attempt to procure coverage, and to recover any costs and expenses arising from such fraud or misrepresentation, including, but not limited to, costs and expenses recoverable in actions at law and in equity.

IX. POST-SERVICE CLAIM PROCEDURE

Note: These claims procedures apply to claims with respect to medical and prescription drug benefits; for further information as to claims with respect to vision benefits, please contact the Vision Claims Processor. See item A and B below for information on deadlines for filing vision claims.

A. Submitting a Claim

Most of the time, in-network providers and facilities will submit claims on your behalf. There may be an instance when a Participant will have to file a claim, particularly for out-of-network providers or facilities. To do so, the Participant must send the following to the Claims Processor or, with respect to drug claims, the Pharmacy Benefit Manager at the address shown on the ID card within 15 months of the date of service. The Participant must send vision claims to the Vision Claims Processor within 12 months of the date of service.

- an itemized bill or receipt (including the pharmacy or provider's name and address, the provider's Tax ID number (if applicable), the drug name (if applicable), the date of service and the diagnosis and procedure codes or description);
- the name of the Employee and the Employee's Unique ID;
- the group number which appears on the ID card;
- the patient's name, age or date of birth and gender;
- any additional information (such as Accident details or the explanation of benefits from the primary insurance company).

The Claims Processor or Pharmacy Benefit Manager will make a determination (process, deny, or request further information) within 30 days of receipt of the claim.

B. Proof of Claims

In order to promptly process claims and to avoid errors in processing that could be caused by delays in filing, written proof of loss should be furnished within 90 days following the date of loss. Failure to furnish written proof within 90 days of loss will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided that such proof is furnished as soon as reasonably possible. Except for the circumstance of legal incapacity of the claimant, proof must be furnished no later than 15 months from the date an expense was incurred or the claim will be denied. Vision claims must be filed within 12 months from the date an expense was incurred or the claim will be denied.

C. Notice of Authorized Representative

The Participant may provide the Plan Administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a Participant and consent to the release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained on the PDRMA website or requested from the Plan Administrator or Agency Benefit Coordinator.

D. Terms Used in this Section

A claim is a “post-service claim” if Plan benefits do not require pre-approval and payment is being requested for medical services already received.

An “urgent care claim” involves any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the Participant’s life or health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of the Participant’s medical condition, subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

E. Time Frame for Benefit Determination

After a completed claim has been submitted to the Claims Processor or Pharmacy Benefit Manager, and if no additional information is required, the Claims Processor or Pharmacy Benefit Manager will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim.

After a completed claim has been submitted to the Claims Processor or Pharmacy Benefit Manager, and if additional information is needed for determination of the claim, the Claims Processor or Pharmacy Benefit Manager will provide the Participant (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the Plan expects to make a decision. The Participant will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim within fifteen (15) calendar days of receipt by the Claims Processor or Pharmacy Benefit Manager of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

F. Notice of Benefit Denial

If the claim for benefits is denied, the Plan Administrator (or its designee) shall provide the Participant (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The following table summarizes the steps in the post-service claim appeal process. Additional details are provided in items G. through M. below.

	Who processes the claim or appeal:	Response issued within:	If Participant disagrees, may take next step, but must do so within:
Post-service claim	Claims Processor or Pharmacy Benefit Manager (drug claims only)	30 calendar days	180 calendar days
Post-service claim appeal	Claims Processor or Pharmacy Benefit Manager (drug claims only)	60 calendar days	4 months
External Appeal – is the appeal eligible to be sent to Independent Review Organization	Claims Processor or Pharmacy Benefit Manager (drug claims only)	6 business days <ul style="list-style-type: none"> • Decision within 5 days • Written notice 1 day later 	If not eligible for External Review, a voluntary appeal may be filed within 30 calendar days. See section N.
External Appeal	Independent Review Organization	45 calendar days	Not Applicable
Expedited External Appeal	Independent Review Organization	72 hours	Not Applicable

G. Appealing a Denied Post-Service Claim

A Participant, or the Participant's authorized representative, may request a review of a denied claim by making written request to the Claims Processor or, with respect to drug claims, the Pharmacy Benefit Manager, within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the Participant feels the claim should not have been denied.

The following describes the review process and rights of the Participant:

1. The Participant has the right to submit documents, information and comments and to present evidence and testimony.
2. The Participant has the right to access, free of charge, relevant information to the claim for benefits.
3. Before a final determination on appeal is rendered, the Participant will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim.
4. The review takes into account all information submitted by the Participant, even if it was not considered in the initial benefit determination.
5. The review by the Claims Processor or Pharmacy Benefit Manager will not give any weight to the reasoning of the original denial, but may use information or medical opinion gathered as part of the analysis.
6. The individual(s) at the Claims Processor or Pharmacy Benefit Manager responsible for reviewing the appeal will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
 - a. The Claims Processor or Pharmacy Benefit Manager will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
 - b. The professional provider utilized by the Claims Processor or Pharmacy Benefit Manager will be neither:
 - (i.) An individual who was consulted in connection with the original denial of the claim, nor
 - (ii.) A subordinate of any other professional provider who was consulted in connection with the original denial.
8. If requested, the Claims processor or Pharmacy Benefit Manager will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

H. Notice of Post-Service Determination on Appeal

The Claims Processor or Pharmacy Benefit Manager shall provide the Participant (or authorized representative) with a written Notice of Appeal Decision within sixty (60) calendar days of receipt of a written request for the appeal.

I. External Appeal Process

A Participant, or the Participant's authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission of coverage. Medical judgment may include, but is not limited to:

1. Medical Necessity;
2. Medical appropriateness;
3. Whether treatment is Experimental or Investigational;
4. Appropriateness of the Health care setting (such as outpatient versus inpatient care or home care versus rehabilitation facility);
5. Level of care; and
6. Effectiveness of a covered expense.

External review also is available with respect to claim denials that involve coverage for services received from out-of-network providers at in-network facilities, Emergency Medical Services received at out-of-network facilities, and Emergency air ambulance services in order to determine compliance with the surprise billing and cost-sharing protections (such as) under the No Surprises provisions found in the Consolidated Appropriations Act of 2021. However, external review is not available when (1) a claim decision does not affect the amount the Participant is obligated to pay to the provider or facility under the Plan; (2) the dispute only involves payment amounts due from the Plan to a provider; and (3) the provider has no recourse against the participant, for amounts unpaid by the plan. Thus, in the common scenario where a payment dispute is between the Plan and a provider, and the balance-billing prohibition under the No Surprises Act prevents the provider from seeking additional payments from the Participant, the external review process does not apply. (Indeed, where the dispute is between the provider and the Plan, the entire appeals process is not available; rather the provider and the Plan may follow a separate negotiations and independent dispute resolution process.)

Requests for external review must be made in writing to the Claims Processor or Pharmacy Benefit Manager within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. (*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.*)

Within five (5) business days of receipt of the request, the Claims Processor or Pharmacy Benefit Manager will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

1. The covered person incurring the claim was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
2. The final internal denial does not relate to the covered person's failure to meet Plan eligibility requirements as stated in Section V, *Eligibility, Enrollment and Effective Dates*;

3. The covered person has exhausted the Plan's appeal process, to the extent required by law, and the Plan has denied in whole or in part coverage for the services; and
4. The services in question are covered by the Plan, but the Plan has denied coverage based upon medical judgment (as described above), there has been a rescission of coverage, or compliance with the surprise billing and cost-sharing protections under the No Surprises Act are implicated; and
5. The covered person has provided all of the information and forms required to complete an external review.

J. Notice of Right to External Appeal

The Plan Administrator (or its designee, such as the Claims Processor or Pharmacy Benefit Manager) shall provide the Participant (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

K. Independent Review Organization

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the Participant in writing of the request's eligibility and acceptance for external review.

L. Notice of External Review Determination

The assigned IRO shall provide the Plan Administrator (or its designee) and the Participant (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the Participant, the Plan and Claims Processor/Pharmacy Benefit Manager, except to the extent that other remedies may be available under State or Federal law.

M. Expedited External Review

The Participant (or the Participant's authorized representative) will have the right to request an expedited external review when the Participant has received:

1. A denial or final internal denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal or a standard external review, respectively, would seriously jeopardize the health or life of the Participant or the Participant's ability to regain maximum function.
2. A final internal denial of benefits that concerns an admission, availability of care, continued stay, or health care item or service for which the Participant receives Emergency Services, but has not been discharged from a facility.

The request may be submitted verbally or in writing to the Plan Administrator. Immediately upon receipt of the request for *Expedited External Review*, the Plan (or its designee) will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, *External Appeal Process*.
2. Send notice of the Plan's decision to the Participant.

Upon determination that a request is eligible for expedited external review, the Plan (or its designee) will do all of the following:

1. Assign an IRO as described in the subsection, *Independent Review Organization*.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the Participant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the Participant (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

N. Voluntary Appeal Process for Appeals Not Eligible for External Review

The Plan offers the following voluntary appeal process for claims that are not eligible for external review and not related to Plan eligibility (see Section V. D.) (*i.e.*, non-medical judgment claims). ***A Participant must have exhausted the appeal process set forth in Section VIII (G, H, I, and J) above before filing an appeal under this voluntary appeal process.*** Unless otherwise set forth below, there is no cost to the Participant under this voluntary appeal process.

1. APPEAL TO THE HEALTH PROGRAM DIRECTOR

If the Participant receives a *Notice of Right to External Appeal* stating that a claim is not eligible for external review, the Participant may file an appeal in writing to the Health Program Director at 2033 Burlington Avenue, Lisle, IL 60532 within thirty (30) days of receiving the *Notice of Right to External Appeal*. The Participant should provide the Health Program Director any information relevant to the claim on appeal. A written response will be issued to the Participant within thirty (30) calendar days of receipt, and if the Participant's appeal is denied, instructions regarding the next step in the voluntary appeal process will be provided.

2. APPEAL TO THE HEALTH BENEFITS COMMITTEE

If the Participant is dissatisfied with the Health Program Director's decision, an appeal may be made in writing to the Health Benefits Committee by mailing the written appeal to the President/Chief Executive

Officer at 2033 Burlington Avenue, Lisle, IL 60532. Appeals should be made within thirty (30) days of the postmarked date on which the decision of the Health Program Director was mailed to the Participant.

The Health Benefits Committee will consider appeals within thirty (30) days of the postmark of the appeal notice and the Participant may request a hearing (such request to be granted at the Health Benefits Committee's discretion). The Participant will be notified in writing of the date, time and place of the hearing at least ten (10) days in advance. The Participant may have witnesses testify on the Participant's behalf, and, at the sole discretion of the Health Benefits Committee, may be represented by legal counsel at the hearing. However, the Participant will be responsible for the Participant's own legal counsel's fees, as well as any costs related to any witnesses the Participant calls to testify. Presentations, including those of the witness(es) will be limited to a total of 60 minutes.

The Health Benefits Committee may elect to continue the claim appeal hearing to a future date if additional time is required to obtain information not presented at the initial hearing. The Health Benefits Committee is not obligated to continue the hearing date to allow the Participant to submit additional evidence. The Health Benefits Committee will render its decision in writing to the Participant postmarked within ten (10) business days after the conclusion of any hearing held before it or if no hearing is provided, postmarked no later than thirty (30) days after the postmarked appeal notice from the Participant.

3. APPEAL TO THE PDRMA BOARD OF DIRECTORS

The Participant may appeal the Health Benefits Committee's decision to the PDRMA Board of Directors. Such request must be in writing and addressed to the Chairman of the Board of Directors at the PDRMA offices at 2033 Burlington Avenue, Lisle, IL 60532 and postmarked within fourteen (14) days of the postmark of the letter by which the Participant was notified of the Health Benefits Committee's decision. The Board of Directors will consider such requests within thirty (30) days of the postmark of the request. The Participant may ask that a hearing be held (such request to be granted at the Board of Director's discretion). The Participant will have a full opportunity to present its position and, at the sole discretion of the Board of Directors, be represented by legal counsel at such hearing. However, the Participant will be responsible for the Participant's own legal counsel's fees as well as any costs related to any witnesses the Participant calls to testify. The Board of Directors will render its decision in writing to the Participant postmarked within ten (10) business days after any hearing held before it or if no hearing is provided, postmarked no later than thirty (30) days after the postmark of the Participant's request for appeal.

The decision of the PDRMA Board of Directors will be final.

NOTE: The decision of a Participant as to whether to submit a benefit dispute to the voluntary appeal process will have no effect on the Participant's rights to any other benefits under the Plan.

A Participant who requests an appeal under the voluntary appeal process may request information to assist in the decision to submit a benefit dispute to the voluntary appeal process, including information related to the Participant's right to representation, the process for selecting the decision maker(s), and the circumstances, if any, that may affect the impartiality of the decision maker(s), such as any financial or personal interests in the result or any past or present relationship with any party to the voluntary appeal process.

O. Foreign Claims

In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for providing the following information to the Claims Processor or, with respect to drugs, the Pharmacy Benefit Manager before payment of any benefits due are payable:

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

X. PRE-SERVICE, CONCURRENT CARE AND URGENT CARE CLAIM PROCEDURE

Note: These claims procedures apply to claims with respect to medical and prescription drug benefits; for further information as to claims with respect to vision benefits, please contact the Vision Claims Processor.

A. Notice of Authorized Representative

The Participant may provide the Plan Administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a Participant and consent to release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained on the PDRMA website or requested from the Plan Administrator or Agency Benefit Coordinator. Notwithstanding the foregoing, requests for prior authorization and other pre-service claims or requests by a person or entity other than the Participant may be processed without a written authorization if the request or claim appears to the Plan Administrator (or its designee) to come from a reasonably appropriate and reliable source (e.g., Physician's office, individuals identifying themselves as immediate relatives, etc.).

B. Terms Used in this Section

A claim is a "pre-service claim" if the Plan conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care – unless the claim involves urgent care, as defined below. Benefits under this Plan that require approval in advance are specifically noted as being subject to prior authorization.

A decision regarding a "concurrent care claim" occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) claims where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) claims where an extension is requested beyond the initially-approved period of time or number of treatments.

An "urgent care claim" involves any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the Participant's life or health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of the Participant's medical condition, subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

C. Time Frame For Pre-Service Claim Determination

4. In the event the Medical Care Management Organization or, with respect to drugs, the Pharmacy Benefit Manager receives from the Participant (or authorized representative) a communication that fails to follow the prior authorization procedure

as described in Section IV. Care Management, but communicates at least the name of the covered person, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the Participant (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

5. After a completed prior authorization request for non-urgent care has been submitted to the Medical Care Management Organization or, with respect to drugs, the Pharmacy Benefit Manager, and if no additional information is required, the Medical Care Management Organization or Pharmacy Benefit Manager will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.
6. After a prior authorization request for non-urgent care has been submitted to the Medical Care Management Organization or Pharmacy Benefit Manager, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the Medical Care Management Organization, the Medical Care Management Organization will, within fifteen (15) calendar days from receipt of the request, provide the Participant (or authorized representative) with a notice detailing the circumstances and the date by which the Medical Care Management Organization or Pharmacy Benefit Manager expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The Participant will have forty-five (45) calendar days to provide the information requested. Failure to respond in a timely and complete manner will result in a denial.

D. Concurrent Care Claims

If an extension beyond the original certification is required, the Participant (or authorized representative) shall call the Medical Care Management Organization for continuation of certification.

If a Participant (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

1. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
2. The inpatient admission or ongoing course of treatment involves urgent care, and the request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the Participant (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received.

If the Health Care Management Organization determines that the Hospital stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the Health Care Management Organization shall:

1. Notify the covered person of the proposed change, and
2. Allow the Participant to file an appeal and obtain a decision before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the Medical Care Management Organization determines that continued confinement is no longer Medically Necessary, additional days will not be certified. (Refer to *Appealing a Denied Concurrent Care, Urgent Care or Pre-Service Claim* discussion below.)

E. Urgent Care Claims

In light of the expedited timeframes for decisions regarding urgent care claims, an urgent care claim for benefits may be submitted to the Medical Care Management Organization or, with respect to drugs, the Pharmacy Benefit Manager by telephone or fax. The claim should include at least the identity of the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval or payment is requested.

Urgent care claims will be ruled upon and the Participant notified as soon as possible taking into consideration medical exigencies but no later than seventy-two (72) hours after the claim was received.

If additional information is required, the Participant will be notified of the additional information as soon as possible but not later than twenty-four (24) hours after the receipt of the claim. The Participant will have forty-eight (48) hours to provide such information (may be provided orally unless written information is requested). Upon timely response, the Participant will be notified of the decision as soon as possible but no later than forty-eight (48) hours after receipt by the Medical Care Management Organization or Pharmacy Benefit Manager of the requested information. Failure to submit requested information timely may result in a denial of such request.

F. Notice of Concurrent Care, Urgent Care or Pre-Service Claim Denial

If a concurrent care claim, urgent care claim or prior authorization request is denied in whole or in part, the Medical Care Management Organization or Pharmacy Benefit Manager shall provide the Participant (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above. Notification of the Plan's adverse benefit determination on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

The following table summarizes the steps in the pre-service claim appeal process. Additional details are provided in items G. and H. below.

	Who processes the claim or appeal:	Response issued within:	If Participant disagrees, may take next step, but must do so within:
Pre-service claims and concurrent care claims	Medical Care Management Organization or Pharmacy Benefit Manager (drug claims only)	15 calendar days	180 calendar days
Pre-service claim appeals and concurrent care claim appeals	Medical Care Management Organization or Pharmacy Benefit Manager (drug claims only)	30 calendar days	4 months
External Appeal – is the appeal eligible to be sent to Independent Review Organization	Medical Care Management Organization or Pharmacy Benefit Manager (drug claims only)	6 business days <ul style="list-style-type: none"> • Decision within 5 days • Written notice 1 day later 	If not eligible for External Review, a voluntary appeal may be filed within 30 calendar days. See Section VIII. N.
External Appeal	Independent Review Organization	45 calendar days	Not Applicable
Pre-service urgent care claim appeals	Medical Care Management Organization or Pharmacy Benefit Manager (drug claims only)	72 hours	4 months

G. *Appealing a Denied Concurrent Care, Urgent Care or Pre-Service Claim*

A Participant (or authorized representative) may request a review of a denied concurrent care, urgent care or Pre-Service claim by making a verbal or written request to the Medical Care Management Organization or Pharmacy Benefit Manager within one hundred eighty (180) calendar days from receipt of notification of the denial. If the Participant (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the Participant:

1. The Participant has the right to submit documents, information and comments and to present testimony.
2. The Participant has the right to access, free of charge, relevant information to the claim for benefits.
3. Before a final determination on appeal is rendered, the Participant will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim.
4. The review takes into account all information submitted by the Participant, even if it was not considered in the initial benefit determination.
5. The review by the Medical Care Management Organization or Pharmacy Benefit Manager will not give any weight to the reasoning of the original denial, but may use information or medical opinion gathered as part of the analysis.
6. The individual at the Medical Care Management Organization or Pharmacy Benefit Manager responsible for reviewing the appeal will not be:
 - a. The individual who originally denied the claim, nor
 - b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
 - a. The Medical Care Management Organization or Pharmacy Benefit Manager will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
 - b. The professional provider utilized by the Medical Care Management Organization or Pharmacy Benefit Manager will be neither:
 - (i.) An individual who was consulted in connection with the original denial of the claim, nor
 - (ii.) A subordinate of any other professional provider who was consulted in connection with the original denial.
8. If requested, the Medical Care Management Organization or Pharmacy Benefit Manager will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.
9. Due to the expedited timeframes for decisions regarding urgent care claims, an urgent care appeal may be submitted by telephone or fax to the Medical Care Management Organization or Pharmacy Benefit Manager. The appeal should include at least the following information:
 - a. The identity of the Participant;
 - b. A specific medical condition or symptom;

- c. A specific treatment, service or product for which approval or payment is requested; and
- d. Any reasons why the appeal should be processed on a more expedited basis.

H. Notice of Concurrent Care, Urgent Care or Pre-Service Determination on Appeal

The Medical Care Management Organization or Pharmacy Benefit Manager shall provide the Participant (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal for concurrent care and pre-service claims. For urgent care claims, the Notice of Appeal Decision will be provided as soon as possible taking into consideration medical exigencies but no later than seventy-two (72) hours after the request was received.

If an appeal with respect to a drug claim is denied based on the drug not being Medically Necessary, the Participant may request a second-level appeal with respect to medical necessity. When an appeal relates to an urgent care claim, the Pharmacy Benefit Manager will perform the second-level medical necessity review automatically, with both level of appeals decided with 72 hours.

Participants who receive a denied appeal of a concurrent care, urgent care, or pre-service care claim may request, if applicable, an External Review under Section VIII. I. an Expedited External Review under Section VIII. M. or where external review is not available, a Voluntary Review under Section VIII. N.

XI. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Note: The Coordination of Benefits procedures apply to claims with respect to medical benefits, but not for prescription drug or vision benefits.

A. Allowable Expense

Allowable Expense means any Medically Necessary, Reasonable and Customary item of expense which is covered at least in part under one or more of the plans covering the person for whom a claim is made. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an Allowable Expense and a benefit paid.

B. Application of Coordination of Benefits

If this is not a Participant's only medical coverage, the benefits payable under this Plan, and any other plan for the allowable expenses incurred during the claim determination period will be coordinated so that the combined benefits paid or provided by all plans equal the amount which would be paid if this Plan was the only coverage.

A Participant must notify the Plan Administrator if the Participant has other coverage. When the Participant files a claim, the Participant should file it with the primary coverage (as determined below) first. When the Participant receives the explanation of benefits from the primary coverage, the Participant should submit a copy of the charges and a copy of the explanation of benefits to the secondary plan. This will expedite the processing of the claim. Failure to comply with this provision or knowingly attempting to circumvent this provision is considered fraud.

One of the Participant's plans will be determined to be primary using the rules below. The primary plan pays its full benefits first. If this Plan is determined to be the secondary plan, the benefits paid in addition to the benefits paid under the primary plan will not be an amount more than the amount the Participant would have received had this Plan been the only coverage. If benefits under this Plan are reduced because of the coordination of benefits, only the reduced amounts will be charged against any applicable benefit limit of this Plan.

The benefits of another plan will be ignored in determining the benefits of this Plan if the rules establishing the order of benefit determination stated below require that this Plan determine its benefits before the other plan.

Following are the rules establishing the order of benefit determination for the purpose of these provisions.

The benefits of a plan which does not contain a Coordination of Benefits provision always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision.

The plan that covers the person directly rather than as a Dependent -- for example, as an Employee, member, subscriber, or retiree (Plan A) -- is primary, and the plan that covers the person as a

Dependent (Plan B) is secondary. However, if the person covered directly is a Medicare beneficiary, and if Medicare is secondary to Plan B and if Medicare is primary to Plan A (for example, if the person is a retiree), then the order of benefits between the two plans is reversed so that Plan B will pay before Plan A.

However, per Federal law, this Plan will pay primary for Dependent children employed in the armed forces who are covered by TriCare.

Coverage through a Health Maintenance Organization (HMO) is primary for a Dependent Participant in this Plan who is also an HMO participant.

If a child is covered under more than one plan, the primary plan is the plan of the parent whose birthday is earlier in the year if:

- a) the parents are married or have a civil union;
- b) the parents are not legally separated (whether or not they have ever been married);
or
- c) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree or administrative order state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period during which benefits are paid or provided before the entity has actual knowledge.

If the parents are not married or are legally separated (whether or not they ever were married) or are divorced, and there is no court decree or administrative order allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and parents' spouses (if any) is:

- a) the plan of the custodial parent;
- b) the plan of the spouse or Civil Union Partner of the custodial parent;
- c) the plan of the non-custodial parent;
- d) the plan of the spouse or Civil Union Partner of the non-custodial parent.

The following rules apply unless the other plan does not have the same rule and as a result the plans do not agree on the order of benefits:

The plan that covers a person as an Employee who is either laid off or retired (or as that Employee's Dependent) is primary and a plan that covers a person as a Dependent of an inactive spouse or Civil Union Partner is secondary. Coverage provided an individual as a retired worker and as a Dependent of that individual's spouse or Civil Union Partner as an active worker will be determined as previously stated above.

If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an Employee, member, subscriber, or retiree (or as that person's Dependent) is primary and the continuation coverage is secondary.

If the preceding rules do not determine the order of benefits, the primary plan is the one that covered the person for the longer period of time, measured from the person's first date of coverage. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if:

- a) the covered person was eligible under the second within 24 hours after the first ended; and
- b) the start of a new plan does not include a change in the amount or scope of a plan's benefits or a change in the entity that pays, provides or administers the plan's benefits, or a change from one type of plan to another (single- to multi-employer, for example).

If none of the preceding rules determines the primary plan, the Allowable Expenses shall be shared equally by the two plans.

This Plan will coordinate benefits on the assumption that the other plan's rules were followed, that the required providers were used, and that the other plan's maximum benefits were paid. The Plan will not pay benefits for expenses that would have been covered by another plan but subsequently were not because the Participant failed to take action required under the other plan's rules to obtain the maximum benefit payable. These include, but are not limited to, using required medical care providers, compliance with required prior authorization or certification, filing claims in a timely manner, etc.

C. Coordination of Benefits with Medicare

Medicare is the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Individuals who have earned the required number of quarters for Social Security benefits within the specified timeframe are eligible for Medicare Part A at no cost. Ineligible individuals age 65 and over may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who pay the full cost of coverage. A voluntary prescription drug benefit (Part D) to the Medicare program is available to "Part D individuals," which Medicare defines as individuals who have coverage under Medicare Part A or Part B and who live in the service area of a Part D plan.

Federal legislation requires that active Employees age 65 and over be given the option to elect either the Employer's plan or Medicare as primary coverage. If the affected Employee elects this Plan as primary coverage, the regular benefits of this Plan will apply. If an Employee elects Medicare as primary coverage, such Employee must disenroll from this Plan.

An active Employee's spouse who becomes entitled to Medicare as a result of reaching age 65 may choose to disenroll such spouse from this Plan such that Medicare is the spouse's only coverage. Alternatively, the Employee may choose to continue such spouse's coverage in this Plan with the spouse enrolling in Medicare as secondary coverage and this Plan's coverage paying its usual benefits

on a primary basis. Or the Employee may choose to continue coverage in this Plan for the Employee and spouse while the spouse delays enrollment in Medicare. (Caution: In order to avoid late enrollment penalties, please review the Medicare rules carefully.)].

The Plan is the primary payer and Medicare is the secondary payer for services that would have been covered by Medicare in each of the following situations:

7. an Employee or Dependent spouse or Civil Union Partner of an Employee covered under this Plan because of current employment who is entitled to Medicare benefits because of age;
8. an Employee or Dependent covered under this Plan as a result of current employment who is entitled to Medicare benefits because of disability;
9. an Employee or Dependent who is entitled to Medicare because of end stage renal disease until the end of the Medicare secondary coordination period.

Benefits for Participants who are eligible for Medicare benefits will be paid according to the Health Care Financing Administration rules and regulations coordinating Medicare with group health plans. This Plan will pay secondary in all instances allowed by HCFA and the Medicare Secondary Payer provisions of the Social Security Act.

When Medicare is the primary payer and an Employee or Dependent entitled to Medicare incurs Hospital, surgical or other charges covered under Medicare and other charges which are not covered under Medicare, this Plan's benefits will cover charges incurred to the extent that they are not covered under Medicare. All of the Coordination of Benefits provisions will apply, including the provision that states that a Managed Care Participant will receive benefits under this Plan at a level that is secondary to the benefits that the Managed Care Option (for example, Medicare Advantage) would have provided had the Participant utilized a participating and/or in-network provider. Furthermore, this Plan shall not provide coverage for costs that may be counted towards meeting a Participant's Medicare Savings Account Policy deductible.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is the primary payer, 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 in both of these parts. Enrollment in Part D is voluntary.

D. Right To Receive Medical Information Necessary To Determine Benefit

By accepting coverage under this Plan, the Participant agrees to supply information about medical conditions and records or other coverage the Participant and any spouse, Civil Union Partner, Domestic Partner, or Dependent(s) have when this Plan asks for it. If this Plan makes a payment and later finds out that it should not have been primary, the Participant must return the excess amount paid to this Plan. All private health information will be kept confidential and will be used on a need only basis.

E. Subrogation/Right of Reimbursement

By accepting benefits under the Plan, a Participant agrees that the Participant and any dependents will be subject to the terms and conditions of this Section E.

The Plan Administrator's intent is that no individual shall receive any profit or be unjustly enriched from the payment of insurance or other benefits from the Plan, or from the payment of any compensation for injuries. Therefore, expenses that are caused by, contributed to, or the responsibility of any Third Party or that are work-related are not Covered Charges under the terms of the Plan to the extent that any amounts are recovered by a Claimant from a Third Party related to such Third Party Incident, regardless of how the recovered amounts are characterized.

To the extent of any payments the Plan makes or may be obligated to make for a claim related to a Third Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant may have against any and all parties responsible for causing the injuries or illness relating to the Third Party Incident. Further, upon settlement or adjudication of any claim arising out of the Third Party Incident, the Claimant shall reimburse the Plan in full for any benefits advanced by the Plan related to the Third Party incident, regardless of how the settlement or award is characterized. The Plan Administrator may require the execution of a Subrogation and Reimbursement Agreement, in a form to be provided by The Plan Administrator, but the Plan's rights to Subrogation and Reimbursement apply regardless of whether the Claimant executes a Subrogation and Reimbursement Agreement.

If Claimant obtains a recovery with respect to the Third Party Incident, no further benefits will be payable from the Plan for any claims related to the Third Party Incident, until the total covered expenses arising out of the Third Party Incident equals the gross amount of the recovery paid to or on behalf of the Claimant. The Plan will then consider only the amount of claims that exceeds the amount of the gross recovery. However, the Plan Administrator, in its discretion, may choose to advance amounts as payment for expenses for medical care in situations where or at a point in time when liability for such expenses has not been established, on the condition that the advance is reimbursed in full upon the settlement or adjudication of the Third Party claim. No loan transaction is created by this advance.

1. DEFINITIONS

For purposes of this Subsection E:

A “Claimant” is the Participant, and includes representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Claimant.

A “Third Party Incident” is any incident where a Third Party causes injuries or illness and/or is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan, or any injury that is work-related.

A “Third Party” is a third party that could include, but is not limited to:

- a third-party tortfeasor or other individual or other entity of any kind who causes harm (such as the driver of another automobile or motor vehicle in an automobile or motor vehicle accident);
- an employee welfare plan or arrangement;
- a medical or hospital benefit plan;
- a no-fault or other automobile or motor vehicle insurance policy;
- an uninsured or underinsured motorist provision or medical pay provision of an automobile or motor vehicle insurance policy;
- a homeowners, school or athletic insurance policy;
- an employer or workers’ compensation insurance carrier;
- a liability insurance policy of any kind or nature; or
- any other Third Party that is obligated to make payments which the Plan would otherwise be obligated to make.

“Subrogation” refers to the Plan’s right to be recover for benefits paid and advanced by the Plan on a claim if a Third Party is responsible for paying the expenses for which the claim is made, by transferring the Claimant’s right to recover those benefits from a Third Party which may include pursuing a cause of action against a Third Party for benefits advanced on behalf of the Claimant. To the extent of any payments the Plan makes or may be obligated to make for a claim related to a Third-Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant or a representative, guardian or custodian of the Claimant may have relating to the Third-Party Incident.

“Reimbursement” refers to the Plan’s contractual right to be reimbursed from expenses advanced on a claim if a Third Party is responsible for paying the expenses for which the claim is made.

“Compensation” for injuries includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement expressly include or exclude medical expenses and disability

recovery. It is specifically intended to give the Plan the right to recover all benefits it paid on a claim, whether or not the Claimant has been made whole.

2. THE PLAN'S RIGHT TO SUBROGATE AND REIMBURSEMENT

The Claimant agrees to reimburse the Plan up to the amount of benefits advanced or paid by the Plan or amounts that the Plan is obligated to pay as well as any future benefits to be paid upon receipt of proceeds from adjudication, settlement or otherwise. The Claimant will first reimburse the Plan on a priority first-dollar basis for all payments the Plan made or may be obligated to make for the claim from any recovery relating to a Third Party Incident, whether by suit, settlement or otherwise, including partial or full recoveries and regardless of whether the Claimant is made whole. Once the Plan makes or is obligated to make payments for benefits on behalf of any Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any Third Party. Notice of a lien is sufficient to establish the Plan's lien against the Third Party.

Claimant will take such action as necessary or appropriate to recover any and all payments made or to be made by the Plan, regardless of whether or not the Claimant is made whole by any subsequent recovery. If the Third Party does not voluntarily pay Claimant for the incurred expenses and Claimant does not sue the Third Party for recovery of the expenses, the Plan has the right to sue the Third Party in Claimant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Claimant further agrees that the Plan's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement.

To the extent of any payments the Plan advances for a claim related to a Third Party Incident, the Plan shall be subrogated to any and all rights of recovery and causes of action that the Claimant or a representative, guardian or custodian of the Claimant may have relating to the Third Party Incident. The Claimant agrees to cooperate fully with the Plan in the prosecution of any claims, causes of action or rights against any Third Party.

The Subrogation right applies on a priority, first-dollar basis to any recovery, whether by suit, settlement or otherwise, whether a partial or full recovery and regardless of whether the Claimant is made whole, from any source liable for making a payment relating to the Injury, illness or condition to which the claim relates. Thus, the Plan specifically rejects the "made whole doctrine" and any other equitable doctrine or law that requires an insured to be "made whole" before Subrogation rights are allowed.

The Plan is entitled to first-dollar recovery regardless of whether the settlement or award is characterized as amounts for medical expenses or as amounts other than for medical expenses. The Claimant waives and agrees to hire an attorney that waives any and all state law, statutory, or common law defenses to first-dollar recovery by the Plan, including but not limited to the make-whole rule, the Common Fund Doctrine, lien reduction statutes, and the collateral source rule.

3. ENFORCEMENT OF SUBROGATION AND REIMBURSEMENT RIGHTS

The Plan has the right to recover amounts representing the Plan's Subrogation and Reimbursement interest through any appropriate legal or equitable remedy, including but not limited to the initiation of

a cause of action to enforce the rights of the Plan, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any Third Party, whether by settlement, judgment or otherwise. The Plan may participate in any legal action Claimant or anyone acting on Claimant's behalf may file against the Third Party to recover the expenses. The Plan's Subrogation and Reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity. The Claimant shall cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, attending depositions, and/or attending or cooperating at a trial in order to effect the Plan's Subrogation rights.

Further, where the Claimant or its agent receives a recovery from any Third Party but does not reimburse the Plan, the Plan shall have the right to offset the amount of future benefit payments on the claims submitted by the Claimant, the Employee (if different from the Claimant) and any of the Employee's Dependents covered under the terms of the Plan until the Plan has recovered the full amount allowed under this Section E.

The Plan's right of Subrogation and Reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Claimant, whether under the doctrines of imperative causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any so called "lien reduction statutes," which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason, including but not limited to contributory fault, comparative negligence, or contributory negligence will not be applicable to the Plan and will not reduce the Plan's Subrogation recovery. The benefits provided under this Plan are secondary to any benefits or coverage provided under any no-fault law or similar legislation or no-fault-type insurance.

4. COORDINATION OF BENEFITS

These Subrogation and Reimbursement rules do not apply to benefits Claimant recovers under another employer-sponsored group health plan if that coverage is subject to coordination of benefits rules.

5. SUBROGATION AND REIMBURSEMENT AGREEMENT

The Plan is not and will not be liable for, nor does it or will it have any obligation to pay, any benefit arising out of a Third-Party Incident. If a claim is submitted for expenses for which someone else is or may be legally responsible, the Claimant, or the Claimant's agent, may be required to execute a Subrogation and Reimbursement Agreement, in a form as to be provided by the Plan Administrator, and return it to the Plan Administrator as soon as possible. However, notwithstanding the preceding, as described above, simply by accepting benefits under the Plan, Participants agree to be subject to the terms and conditions of this Section E. and any Subrogation and Reimbursement Agreement. Failure to comply with this Section E. may result in offsets or other collective actions against the Employee and/or the Employee's Dependents. If Claimant is a minor or is otherwise legally incompetent, Claimant's parent, legal guardian or "next friend" must execute any Subrogation and Reimbursement Agreement on the Claimant's behalf.

The Subrogation and Reimbursement Agreement will be binding upon the Claimant whether the payment received from the Third Party or its insurer results from a legal judgment, an arbitration award, a compromise settlement, or any other arrangement. The Subrogation and Reimbursement Agreement

also will be binding on any recovery made by the Claimant, even if the recovery does not include medical expenses.

Claimant agrees to instruct and cause any attorney(s) retained on the Claimant's behalf to honor and enforce the terms of this Section E. or any Subrogation and Reimbursement Agreement before disbursing the proceeds of any recovery arising out of the Third-Party Incident.

6. MISCELLANEOUS SUBROGATION RULES

a) Separate Rights.

The rights to Reimbursement and Subrogation set forth in this Section E., are separate and distinct rights and obligations. The failure or invalidity, in whole or in part, of one such right or obligation will not impair or otherwise adversely affect any such other right or obligation.

b) Attorneys' Fees.

The Plan specifically disavows any claim the Claimant and/or Claimant's attorney may make under the "Common Fund Doctrine." This means that the Plan shall not be responsible for any of the Claimant's court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Plan had agreed in writing to pay such fees or costs. The Claimant is specifically prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of the Claimant's rights of recovery against a Third-Party or the Plan's Subrogation and Reimbursement rights as set forth herein.

Claimant agrees to indemnify the Plan for any cause of action brought by the Claimant's current or former attorney against the Plan seeking payment of fees or seeking to assert quantum meruit or the common fund doctrine.

c) Plan Right to Waive.

The Plan may waive its Subrogation or Reimbursement rights, or any part thereof, if the Plan Administrator decides that such action is in the best interest of the Plan and its Participants.

d) Anti-Assignment.

By accepting benefits under the Plan, Claimants are prohibited from doing anything that will impair, release, discharge or prejudice the Plan's Subrogation or Reimbursement rights. No Claimant may assign any rights or causes of action that such Claimant might have against a Third-Party, which would grant the Claimant the right to recover medical expenses or other damages, without the express, prior written consent of the Plan Administrator. The Plan's Subrogation and Reimbursement rights apply even where the Employee, Dependent or Third Party has died as a result of the Third Party Incident and the Claimant is asserting a wrongful death, survivor, or similar claim under the Wrongful Death Act (740 ILCS 180/1), the Illinois Survival Act (755 ILCS 5/27-6), the Family Expense Act (750 ILCS 65/15),

or any similar cause of action against the third-party under the laws of any state. The Plan's right to recover by Subrogation or Reimbursement shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

e) Maximum Amount of Recovery.

Neither Claimant nor any other person will be required to reimburse to the Plan more than the benefits the Plan pays on the claim, or more than the gross amount the Claimant receives in recovery, whichever is less, without regard to attorney's fees and expenses incurred in obtaining such recovery.

f) Fiduciary Status.

Should any money subject to the terms of this Section E. or a Subrogation and Reimbursement Agreement be recovered by or on behalf of any Claimant, and such money is transferred to the Claimant, Claimant agrees that such money is a Plan asset and that Claimant is a fiduciary to the Plan with respect to that money. If the Claimant is a fiduciary pursuant to the foregoing, a failure to comply with this Section E. or the Subrogation and Reimbursement Agreement shall be considered a breach of fiduciary duty, and the Plan Administrator may enforce the terms of this Section E. or the Subrogation and Reimbursement Agreement through legal action, reduction of benefits, or any other available legal or equitable means.

XII. PARTICIPANT RIGHTS

All Plan Participants may, at the discretion of the Plan:

10. Examine, without charge, at the Plan Administrator's office, relevant Plan documents.
11. Obtain copies of Plan documents and other Plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies.)

The Participants in this Plan have the sole right to select their own providers of health care. The Plan will not choose a provider for any Participant, or have any liability for any acts, omissions, or conduct of any provider. The Plan's only obligation is to make payments according to the terms of this Plan Document. The payments that the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

A Participant will have the right to assign the payment of any benefits for which the Claimant is eligible under this Plan to any eligible provider of services. If a provider makes a representation to the Claims Processor that a person covered under this Plan has made an assignment of benefit payments to the provider, the Claims Processor will make payment to the provider based on that representation.

XIII. GENERAL PROVISIONS

A. Legal Compliance/Conformity

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Employer's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Employer's policy is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

B. Effect of Prior Coverage

Coverage for any Participant under this Plan Document replaces any prior coverage in effect for that Participant provided by the Employer under any immediately prior plan document or policy.

C. Severability

In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

D. Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and the Employees or to be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to affect the right of the Employer to discipline or discharge any Employee at any time or the right of the Employee to terminate employment at any time. Nor shall anything in this Plan be deemed to give the Employer the right to require any Employee to remain in its employ or give the right to any Employee to be retained in the employ of the Employer.

E. Headings

Headings are for reference and not for interpretation or construction.

F. Word Usage

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

G. Defined Terms

Terms throughout this Plan Document that have been capitalized are defined terms and can be found in Section XIII if not defined elsewhere in the document.

H. Titles for Reference

The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

I. Clerical Error

No clerical errors made by the Employer, Plan Administrator, or the Claims Processor in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made.

J. Misstatements

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

K. Refund of Overpayments

If the Plan pays benefits for expenses incurred on account of a Covered Participant, that Covered Participant, or any other person or organization that was paid, must provide a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Participant or did not legally have to be paid by the Covered Participant.
- All or some of the payment the Plan made exceeded the benefits under the Plan.

The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the terms of the Plan. If the refund is due from another person or organization, the Covered Participant agrees to help the Plan obtain the refund when requested.

If the Covered Participant, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

L. Notice of Specific Rights Under the Law

1. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Although the Plan was not required to do so, the Plan has elected to comply with the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans from restricting medical benefits for a hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean

section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). Consistent with this federal law, the Plan will not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours, as applicable.

2. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Although the Plan was not required to do so, the Plan has elected to comply with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). WHCRA provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. To the extent WHCRA applies, coverage will be provided for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. Such coverage will be subject to annual deductibles, copayments, and coinsurance provisions as are consistent with those established for other medical and surgical benefits under the Plan.

3. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Plan complies with the Genetic Information Nondiscrimination Act of 2008 (GINA), which protects Americans against discrimination based on their genetic information as applied to health insurance and employment. Specifically, GINA prohibits a group health plan from denying coverage or charging a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder.

4. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The Plan complies with the Mental Health Parity and Addiction Equity Act of 2008 which requires that the annual or lifetime dollar limits on mental health and substance abuse benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. Federal law also requires that plans providing both health/surgical and mental health/substance abuse benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

5. HIPAA PRIVACY NOTICE

Participants have been furnished a Notice of Privacy Practices describing the practices the Plan will follow with regard to "protected health information." For a copy of the notice, contact the Plan Administrator or visit the PDRMA website at www.pdrma.org.

XIV. DEFINITIONS

Capitalized terms in this document shall have the meaning set forth in this section.

Accident and Accidental means an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010, as amended, and as sometimes referenced as “PPACA” or “ACA.”

Ambulatory Surgical Center is 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.

Ancillary Services mean emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no network provider who can furnish such item or service at such facility.

Approved Clinical Trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or another life-threatening disease or condition that is (i) federally funded or approved, (ii) conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a drug trial that is exempt from having such an investigational new drug application.

Autism Spectrum Disorder means a pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger’s disorder, and pervasive developmental disorders not otherwise specified. The diagnosis of Autism Spectrum Disorders includes one or more tests, evaluations, or assessments to diagnose whether an individual has an Autism Spectrum Disorder that is prescribed, performed, or ordered by (a) a Physician licensed to practice medicine in all its branches or (b) a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders.

Birthing Center means any freestanding or Hospital-based facility which provides an “at home” atmosphere for the delivery of babies. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a Licensed Nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means a twelve-month period beginning on the first day of January and ending on the last day of the following December.

Certified Speech Therapist means an individual or agency licensed by the state or an individual or agency certified by the American Speech and Hearing Association or the National Association of Speech and Hearing Agencies.

Chiropractic Care 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 to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Civil Union Partner means a person who has entered into a “civil union,” as defined by the Illinois Religious Freedom Protection and Civil Union Act, with the Employee.

Claims Processor means Blue Cross and Blue Shield of Illinois for medical plans and Davis Vision for vision plans.

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

Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation), and you must require skilled nursing service on an intermittent basis under the direction of your Physician, a physician assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for private duty nursing service or custodial care service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

Covered Charge means any expense that is eligible for benefits and not otherwise excluded under this Plan.

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means a spouse, Civil Union Partner, Domestic Partner, or child who meets the requirements for such status as set forth in the Eligibility section of this document (Section V).

Domestic Partner means an individual who meets the requirements for such status as stated in the Eligibility section of this document.

Durable Medical Equipment means equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of a Sickness or Injury, (d) is not disposable or non-durable, and (e) is appropriate for use in the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, insulin, insulin pumps, and diabetic supplies such as blood sugar monitors (unless purchased under the Prescription Drug Program), blood and blood plasma (unless replaced by or for the patient), commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies and ventilators, and wigs when purchased due to hair loss associated with chemotherapy.

Employee means a person who works for an Employer in an employer/employee relationship. The term also refers to a retiree as indicated in Section V (Eligibility) and further explained in Section VI (Extensions of Coverage). The term does not include, however, an individual providing services as an independent contractor.

Employer is one of the Member Agencies (or all Member Agencies collectively).

Emergency Medical Condition is a medical condition (including a Mental Health Disorder or Substance Abuse) manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Whether a medical condition constitutes an "Emergency Medical Condition" is not determined solely on the basis of the ultimate diagnosis codes.

Emergency Services are outpatient and inpatient services provided with respect to an Emergency Medical Condition and include treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition and medical treatment necessary to stabilize the person (in other words, 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 person from the facility). Emergency Services include treatment of an Emergency Medical Condition by an Urgent Care Facility if such Urgent Care Facility is permitted by applicable state licensure laws to provide such services.

Essential Health Benefits are currently broadly defined under the Patient Protection and Affordable Care Act as the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs (only applicable to generics unless a generic is not available or not medically appropriate); rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic disease management. Essential Health Benefits also are defined under the Act to include pediatric oral and vision care services, but this only applies to dental and vision benefits that are integrated with medical benefits, which is not the case for any pediatric dental or vision benefits offered by this Plan.

Although the Act does not define Essential Health Benefits in any greater specificity, under applicable regulatory guidance, the Plan may rely upon state “benchmark plans” as a reference point for determining what constitutes an ‘Essential Health Benefit.’

Experimental or Investigational means a treatment (other than off label drug use) described as follows:

- The treatment is governed by the US Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
- The treatment is subject to ongoing Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute, or FDA; or
- There is documentation in published US peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine safety, toxicity or efficacy of the treatment.

Family means an Employee and any Dependents. Under any benefit section, a “covered Family member,” as of any given time, is a Family member for whom coverage is then in force under the section.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same active ingredients and produces the same effect in the body. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

HIPAA is the Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency is an organization that meets each of the following requirements:

- It primarily is engaged in and duly licensed, if licensing is required by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
- It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a Physician or Registered Nurse.
- It maintains a complete medical record on each covered person.
- It has a full-time administrator.
- It qualifies as a reimbursable service under Medicare.

Hospice Care Agency is an organization the main function of which is to provide counseling and medical services and possibly room and board and supplies to a terminally ill covered person and which meets all of the following requirements:

- It has obtained any required state or governmental Certificate of Need approval.

- It provides service 24 hours per day, seven day per week.
- It is under the direct supervision of a Physician.
- It has a nurse coordinator who is a Registered Nurse.
- It has a social service coordinator who is licensed.
- It is an agency that has as its primary purpose the provision of hospice services.
- It has a full-time administrator.
- It maintains written records of services provided to the covered person.
- It is licensed by the state in which it is located, if licensing is required.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of Registered Nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a Rehabilitation Facility for rehabilitative care.
- A facility operating legally as a psychiatric Hospital or residential treatment facility for Mental Health Disorders and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a Registered Nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hospital or Other Confinement. Any confinement in a Hospital or Skilled Nursing Facility for which a charge is made for room and board.

Infertility means a disease, condition, or status characterized by:

- 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 clock;
- a person's inability to reproduce either as a single individual or with a partner without medical intervention; or
- 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.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours per day.

Legal Guardianship means a person (the Legal Guardian) is 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.

Licensed Dietician (L.D. or L.D.N.) means a professional person who is licensed to perform dietetics and nutrition-related services by the state in which the person performs such service and who is performing within the scope of that license.

Licensed Practical Nurse or Licensed Vocational Nurse means an individual who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Lifetime, used in this Plan in the context of benefit maximums and limitations, refers to the “lifetime” of coverage under this Plan, not to the term of an individual’s life.

Maintenance Care: Treatment after achieving maximum medical recovery when further treatment is primarily to maintain the maximum level of recovery.

Medical Care Management Organization is the organization that performs the services described in Section IV.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is required for the treatment or management of the patient’s symptoms or condition; is consistent with 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 and dental services; is not conducted for research purposes; and is the most efficient and economical level of services which can be safely provided to the patient. Merely because a Physician or Dentist recommends, prescribes, orders or approves certain care does not mean that it is considered Medically Necessary for purposes of determining coverage under the Plan.

Hospital or Other Confinement is not considered Medically Necessary when it is determined that the medical services provided did not require a Confinement but could have been provided in a Physician’s office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient’s condition.

The Medical Care Management Organization (or the Prescription Benefit Manager with respect to drugs) has the discretionary authority to decide whether care or treatment is Medically Necessary.

Note: A determination as to whether care or treatment is “Medically Necessary” under the Plan is

merely a decision regarding provision of benefits under the Plan. Decisions as to the appropriate treatment and care must be made by you in consultation with your Physician or Dentist.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act as amended.

Member Agency means the park district, forest preserve and special recreation agencies that have contracted for benefits through PDRMA, including PDRMA itself.

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

Morbid Obesity is defined as being 100% or 100 pounds over a Participant's ideal body weight.

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

Non-Emergency Medical Condition is a Sickness or Injury which does not qualify as an Emergency Medical Condition.

Non-Essential Health Benefits are benefits not determined to be Essential Health Benefits under the Patient Protection and Affordable Care Act (see Essential Health Benefits) and any subsequent regulations.

Open Enrollment is an annual designated period of time the Plan Administrator allows eligible Employees to enroll or disenroll from the Plan (other than a Special Enrollment or as permitted by the Plan Administrator). During Open Enrollment, an eligible Employee may also:

- Add eligible Dependents.
- Remove eligible Dependents.
- Switch plan elections as defined by their Employer.

Orthotic Appliances and Devices means a type of corrective appliance or device, either customized or available "over the counter" to support a weakened body part, including, but not limited to, surgical dressings, casts, trusses, crutches, specially designed corsets, leg braces, extremity splints, and walkers.

Out-of-Network Rate means an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or (ii) if there is no such agreement, an amount determined by state law, or (iii) if there is no such agreement and no amount determined by state law, the payment amount agreed to by the Plan and the provider or facility, or (iv) if none of the above conditions apply, the amount determined through an independent dispute resolution process.

Outpatient Care or Outpatient refers to treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed

patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center or the patient's home.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Physician means a doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of dental surgery (D.D.S.), doctor of medical dentistry (D.M.D.), doctor of podiatry (D.P.M.), doctor of chiropractic (D.C.), acupuncturist, audiologist, certified nurse anesthetist, certified nurse midwife, occupational therapist, optometrist (O.D.), nurse practitioner (N.P.), licensed practical nurse (L.P.N.), physician assistant (P.A), physiotherapist, registered physical therapist, speech language pathologist and any provider licensed by the state in which they practice for the treatment of Mental Health Disorders and/or Substance Abuse (including but not limited to psychologists, psychotherapists, licensed clinical social workers, licensed clinical professional counselors and licensed marriage and family therapists). All of the above providers must be licensed and regulated by a state or federal agency and must be acting within the scope of their respective licenses.

Plan means the PDRMA Health Program, which is a benefit plan for certain Employees of PDRMA's Member Agencies and is described in this document.

Plan Administrator is the Park District Risk Management Agency "PDRMA."

Plan Year is the twelve-month period beginning on January 1 and ending December 31.

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

Prescription Benefit Manager is the prescription drug vendor contracted by the Plan Administrator to provide benefits for prescription drugs.

Prosthetic Appliances and Devices means a type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial eyes, larynx, heart pacemakers, or corrective lenses needed after cataract surgery.

Radiological Imaging includes, but is not limited to, imaging technologies like x-rays, CT scans, mammography, bone densitometry, nuclear medicine, echocardiograms, MRIs, and Ultrasounds to diagnose and treat diseases.

Reasonable and Customary Charge is in the case of services provided by in-network providers, the negotiated rate that the provider has agreed to accept as a condition of participation in the PPO. In the case of services provided by non-PPO providers who have a contract with the Claims Processor to provide services at contracted rates, the Reasonable and Customary Charge is the amount of covered expenses that does not exceed the contracted rate. In the case of non-PPO providers who do not have a contracted rate, the Reasonable and Customary Charge will be 300% of the base Medicare rate.

The Plan will base Plan benefits on the actual charge billed if it is less than the Reasonable and Customary Charge.

Recognized Amount means an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

Registered Nurse means a professional person who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Rehabilitation Facility means an inpatient medical facility that is licensed as a Hospital or freestanding Rehabilitation Facility, where licensure is required, or it may be CARF (Commission on Accreditation of Rehabilitation Facilities) accredited. Physicians and Registered Nurses are on staff and available. This type of facility provides physical, occupational and speech therapy by licensed therapists and also has available a program of structured cognitive therapy. Social work and discharge planning are provided, to include planning for care and equipment needs after discharge.

Sickness means an illness or disease that results in a loss covered by the Plan. This term includes Pregnancy, sterilization and abortion procedures, Mental Health Disorder and Substance Abuse.

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

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

Its services are provided for compensation and under the full-time supervision of a Physician or with Physician services available at all times under an established agreement.

It provides twenty-four hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse (R.N.).

It has established methods and written procedures for the dispensing and administration of drugs.

It maintains a complete medical record on each patient.

It has an effective utilization review plan.

It is not, other than incidentally, a place for the provision of rest, custodial care, or education or for care required by reason of age.

It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Specialty Medications are drugs that are injectable, infused, high cost, and/or require specialized delivery or refrigeration. For example (not an exhaustive list), Specialty Medications are often used in the treatment of Allergic Asthma, Cancer, Crohn's Disease, Cystic Fibrosis, Growth Hormone Disorders, Hepatitis C, Hereditary Angioedema, HIV, Immune Disorders, Infertility, Lysosomal Storage Disorders, Multiple Sclerosis, Osteoporosis, Psoriasis, Pulmonary Arterial Hypertension, Respiratory Syncytial Virus, Rheumatoid Arthritis, and Transplant.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs or tobacco that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on ordinary caffeine-containing drinks.

Surgical Procedure shall include but not be limited to one or more of the following types of medical procedures performed by a Physician:

- Incision, excision or electrocauterization and shave biopsy of any part of the body.
- Manipulative reduction or treatment of a fracture or dislocation, including application of a cast or traction.
- Laser beam photocoagulation.
- Suturing of a wound, surgical debridement and dressing of burns; acne surgery.
- Diagnostic and therapeutic endoscopic procedures.
- Surgical injection treatments or aspirations.
- Cardiac catheterizations and other arterial or venous catheterizations.
- Maternity procedures.
- Transplantation of organ(s).

Surviving Spouse means an individual who meets the requirements for such status as determined by IMRF and is receiving a Surviving Spouse pension.

Urgent Care Facility shall mean a facility other than a free clinic providing medical care and treatment of Sick or Injured persons on an Outpatient basis. In addition, it must meet all of the following tests:

- It is accredited by the Joint Commission on Accreditation of Hospitals or is approved by the federal government to participate in federal and state programs.
- It maintains on-premise diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified Physicians.
- It is operated continuously with organized facilities for operative surgery on the premises.
- It is staffed with continuous Physician services and registered professional nursing services whenever a patient attends the facility.
- It does not provide services or other accommodations for patients to stay overnight.

Waiting Period shall mean any period of time that must pass before coverage for an eligible Employee can become effective under the Plan.

XV. HIPAA PRIVACY STANDARDS FOR PROTECTED HEALTH INFORMATION

This Section applies to the Plan only to the extent that the Health Program constitutes a “health plan” that uses or discloses “protected health information” (“PHI”) including electronic PHI as those terms are defined in 45 CFR Parts 160, 162 and 164 (the “HIPAA Privacy Rules”). This Section also is intended to allow disclosure of PHI to PDRMA, the Plan Sponsor for the purposes specified below. For purposes of this Section, terms defined in the HIPAA Privacy Rules but not in this Plan shall be interpreted and administered in accordance with those provisions. Hereinafter, covered Employees and Dependents are referred to as Individuals.

Generally, PHI, as defined under HIPAA, includes all individually identifiable information related to an individual’s past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic format. PHI does not include information that has been de-identified. De-identified information is information that does not identify the individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

Electronic PHI (“ePHI”) refers to PHI that is transmitted by or maintained in electronic media including electronic storage media (such as hard drives, magnetic tapes or disks, optical disks, and digital memory cards) and electronic transmission media (such as the Internet, extranets, leased lines, dial-up lines, private networks, telephone voice response systems and faxback systems, but not paper-to-paper faxes or voicemail messages).

To the extent that there is any conflict between this Section and any other Plan provisions, the terms of this Section as set forth below control. The Plan Administrator and its duly authorized representatives retain full discretion in interpreting and applying these rules. The Plan maintains a Notice of Privacy Practices that provides a description of the rights of Individuals under the HIPAA Privacy Rules. Individuals may contact the Plan Administrator if they need a copy of the Notice of Privacy Practice or have questions about the privacy of their health information, or they can visit the PDRMA website at www.pdrma.org.

A. Disclosure of Summary Health Information

The Plan may disclose to PDRMA governing bodies summary health information if the PDRMA governing body requests such information for the purposes of approving the budget and member contributions, obtaining premium bids from vendors of health insurance coverage or for the purpose of deciding whether to amend or terminate the Plan. Summary health information is information that summarizes the claims history, claims expenses, or type of claims experienced by the individuals for whom health benefits have been provided under the Plan, from which individual identifiers (other than certain limited geographical information) such as names and social security numbers, have been removed. The Plan may disclose summary health information to a Member Agency upon receipt of a HIPAA-compliant authorization signed by the impacted Individual.

B. Use and Disclosure of Protected Health Information (PHI)

1. The Plan will use and disclose PHI in accordance with HIPAA, but only to the extent that it determines that:
 - a. such use or disclosure is needed for the “payment” of Individual claims, the “treatment” of Individuals under the Plan, or the “health care operations” of the Plan, as such terms are defined in the HIPAA Privacy Rules;
 - b. such use or disclosure is required by law;
 - c. such use or disclosure is needed to determine whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance plan or HMO offered as part of the Plan.
 - d. such use or disclosure has been authorized by the relevant Individual(s) in accordance with the HIPAA Privacy Rules; or
 - e. such use or disclosure is appropriate under the portions of the HIPAA Privacy Rules governing access to PHI, requests to amend PHI, and accounting of disclosures of PHI.
2. The Plan will not disclose any PHI to a Member Agency unless the impacted Individuals sign an authorization to release PHI to the Member Agency.
3. The Plan will provide individuals with a Notice of Privacy Practices and will notify Individuals of any modifications thereto.
4. The Plan will use PHI only to the extent and in accordance with the uses and disclosures permitted by the HIPAA Privacy Rules. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

Payment includes activities undertaken by the Plan to obtain member contributions or determine or fulfill its responsibility for coverage and provision of the plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- a. Determination of eligibility, coverage and cost sharing amounts (for example, cost of benefit plan maximums and copayments as determined for an Individual’s claim);
- b. Coordination of benefits;
- c. Adjudication of health benefit claims (including appeals and other payment disputes);
- d. Establishing Employee contributions;
- e. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- f. Billing, collection activities and related health care data processing;
- g. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Individual inquiries about payments;
- h. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- i. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- j. Utilization review, including prior authorization, concurrent review and retrospective review; and
- k. Subrogation and third-party reimbursement of the Plan.

Health Care Operations include, but are not limited to, the following activities:

- a. Quality assessment;

- b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- c. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- d. Underwriting, premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- e. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- f. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- g. Business management and general administrative activities of the Plan, including, but not limited to:
 - (i) management activities relating to the implementation of and compliance with HIPAA administrative simplification requirements; or
 - (ii) customer service, including the provision of data analyses for Member Agencies;
 - (iii) resolution of internal grievances; and
 - (iv) due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest is a “covered entity” under HIPAA, or, following completion of the sale or transfer, will become a covered entity.

C. Plan Disclosure of PHI to Member Agencies Pursuant to Authorization

With an authorization from an Individual, the Plan may disclose the Individual’s PHI to a Member Agency for purposes related to administration of health expense reimbursement arrangements, pension plans, disability plans, reciprocal benefit plans, and other valid benefit programs.

D. With Respect to PHI, PDRMA Agrees to Certain Conditions

PDRMA agrees to:

1. not use or further disclose PHI other than as permitted or required by this document or as required by law;
2. ensure that any agents, including any subcontractor to whom PHI is provided, enter into an agreement that signifies intent to comply with the same restrictions and conditions that apply to PDRMA with respect to PHI;
3. not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Individual;
4. report to the Plan’s Privacy Officer PHI use or disclosure that is inconsistent with the uses or disclosures provided of which it becomes aware. Specifically, PDRMA will report to the Privacy Officer any breach as defined by 45 CFR §164.402 and cooperate with the Privacy Officer’s efforts to notify the applicable parties of such breach;

5. make PHI within control available to an Individual in accordance with HIPAA's access requirements;
6. make available the information in its possession required to provide an accounting of disclosures in accordance with CFR § 164.528;
7. make its internal practices, books and recordings relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA;
8. cooperate with the Plan's efforts to comply with the breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408
9. make PHI within control available for amendment and incorporate any amendments to PHI in accordance with HIPAA; and
10. if feasible, return or destroy all PHI received from the Claims Processor, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between Plan and PDRMA Must Be Maintained

In accordance with HIPAA, only the following PDRMA staff may be given access to PHI:

1. Health Program Coordinator
2. Wellness Consultant
3. Health Program Operations Supervisor
4. Health Program Director
5. Director of Finance
6. Accounting Supervisor
7. Accounting Specialist
8. The Plan's Privacy Officer
9. Other staff as designated by the Health Program Director, as may be necessary to administer the Plan.

In accordance with HIPAA and only after obtaining a HIPAA-compliant authorization from the Individual, only the following Member Agency staff will be given access to PHI:

1. The Member Agency's Privacy Officer
2. Employees of the Member Agency who are responsible for any aspect of administration of benefits (including, but not limited to, employees with responsibility for payroll functions).

The persons described in this Subsection E may have access to and use and disclose PHI only to the extent necessary for them to perform administration functions (including Payment activities and Health Care Operations as described above) on behalf of the Plan.

F. Privacy Officer

The Privacy Officer of the Plan as appointed by the Plan Administrator shall be responsible for:

1. development and implementation of the Plan's privacy policy (as provided in the HIPAA Privacy Rules) and administrative procedures;

2. receiving Individual complaints and responding to Individual requests for additional information about such policies and procedures; and
3. coordinating the Plan's efforts to comply with the breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408; and
4. receiving and responding to reports regarding any PHI use or disclosure that is inconsistent with the permitted uses or disclosures.

G. Minimum Necessary

In no event shall the use or disclosure of PHI by the Plan exceed the scope reasonably determined by the Plan to be the minimum use or disclosure necessary for the intended and permitted purposes of the use or disclosure. Disclosures made on a routine and recurring basis will be made pursuant to standard policies and procedures that limit the disclosure to the minimum necessary. All other disclosures will be reviewed on an individual basis to ensure that the disclosure is limited to the information reasonably necessary to accomplish the purpose of the request.

H. Legal Standards

This Plan shall be administered and interpreted to comply with any applicable state law, except to the extent that such state law is preempted by HIPAA.

I. Noncompliance Issues

If any PDRMA employees do not comply with the provisions of this Section XIV, PDRMA shall resolve issues of noncompliance, including through application of disciplinary sanctions up to an including discharge as stated in the personnel policies of PDRMA relative to disciplinary and termination procedures. PDRMA shall take whatever actions are necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated or removed pursuant to this paragraph, the Plan reserves the right to direct that PDRMA modify or revoke any person's access to or use of PHI. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Officer at the telephone number and address provided in the Plan's Notice of Privacy Practices.

J. Protection of Electronic PHI

If electronic PHI ("ePHI") is created, received, maintained, or transmitted to or by PDRMA on behalf of the Plan, PDRMA will do the following:

- Ensure that the "adequate separation" described above is supported by reasonable and appropriate security measures;
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such PHI;
- Ensure that any agent (including a subcontractor) to whom it provides such PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware. For purposes of this provision, "security incident" is defined as the attempted or successful unauthorized access, use,

disclosure, modification, or destruction of information or interference with system operations in an information system.

Notwithstanding the above, if the only ePHI that is disclosed is pursuant to a HIPAA-compliant authorization or is limited to Summary Health Information (as defined in the HIPAA Privacy Rules) disclosed for the purpose either of obtaining premium bids for providing health insurance coverage under the Plan, or modifying, amending or terminating the Plan, and information regarding an individual's participation, enrollment or disenrollment, the requirements of this section do not apply.

XVI. IDENTIFICATION OF PLAN

PLAN: PDRMA Health Program

PLAN SPONSOR:

PDRMA
2033 Burlington Avenue
Lisle, IL 60532
630-435-8998

PLAN SPONSOR TAX ID NO.: 36-3494500

MEDICAL CLAIMS PROCESSOR:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112
800-772-6895

Blue Cross and Blue Shield of Illinois GROUP NUMBERS.: 434259, 434260, 434261, 434262, 434263, 434264, 434265, 434266, 434267, 434268, 434269, 434270, 434271, 434272, 434273, 434274, 434275, 434277

VISION CLAIMS PROCESSOR

Davis Vision
P.O. Box 1525
Latham, New York 12110
800-999-5431

TYPE OF BENEFITS PROVIDED: See Schedule of Benefits

TYPE OF PLAN ADMINISTRATION: Self-Funded Third Party

PLAN ADMINISTRATOR/AGENT FOR LEGAL PROCESS:

PDRMA
2033 Burlington Avenue
Lisle, IL 60532
630-435-8998

CONTRIBUTIONS TO PLAN:

Funding for the Plan comes partially from contributions of the Member Agencies and partially from contributions of covered Employees.

PLAN YEAR/FISCAL YEAR END: December 31st