Wespath Benefits and Investments
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HealthFlex Benefits Booklet

Blue Cross and Blue Shield of Illinois

- Preferred Provider Medical and Behavioral Health Benefits (PPO Plan)
- HRA Plans
- HSA Plans

Effective January 1, 2020

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Welcome

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois [doing business as Wespath Benefits and Investments (Wespath)] has prepared this Benefit Booklet to help you understand your health benefits administered by Blue Cross and Blue Shield of Illinois (BCBSIL or the Claims Administrator). Please read it carefully.

About the Plan

The General Conference of The United Methodist Church permitted the establishment of a welfare benefit program for clergy and lay employees effective January 1, 1961. The Hospitalization and Medical Expense Program, also known as HealthFlex (the Plan), is maintained for the benefit of clergy and lay employees (and their Dependents) of The United Methodist Church.

The Plan is a "Church Plan" as defined in Section 414(e) of the Internal Revenue Code of 1986 (Code), as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan's status as a Church Plan has a significant legal meaning; you can read more about it in the section titled *Other Important Provisions*.

Serving The United Methodist Church

The General Conference established Wespath to supervise and administer the employee benefit plans of The United Methodist Church. Wespath, in accordance with the provisions of *The Book of Discipline*, performs its duties for the supervision and administration of the Plan, and fulfills its responsibilities in the spirit of the Church's mandate for inclusiveness and racial and social justice.

Our Role in Providing Health Care Coverage and Controlling Costs

It is our mission to deliver compassionate Christian care balanced with financial stewardship on behalf of all Participants. We strive to ensure clergy and lay employees across the denomination are able to elect comprehensive health care coverage through the Plan. There are a variety of ways Wespath is responding to the increasing costs of health care, including benchmarking the Plan to make sure it remains competitive, evaluating the Plan's quality and networks, and negotiating with third-party administrators to ensure the Plan obtains the best possible rates for the desired services. There are things you can do too, to control your own health care costs as an informed consumer of health care services. You can learn more about the steps you can take to control your health care costs at the HealthFlex/WebMD website or by asking your Physician.

Explanation of Terms

You will find terms starting with capital letters throughout this Benefit Booklet. To help you understand your benefits, most of these terms are defined in the *Definitions* section of this Benefit Booklet.

Plan Sponsor

Your Plan Sponsor is the employer or Conference through which your coverage under the Plan is coordinated. Your Plan Sponsor has elected to participate in the Plan through an adoption agreement with Wespath. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor in addition to Wespath.

Confidentiality and HIPAA

The privacy of the health records of Plan Participants and their Dependents is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, Wespath employees and Plan representatives and agents (such as Blue Cross and Blue Shield of Illinois, OptumRx and others) may not release Protected Health Information, known as PHI, to a Participant's Plan Sponsor, Spouse or any other entity (unless required by law) unless the Participant authorizes such release. HIPAA also applies when you want PHI to be shared among health plans and Providers for reasons other than payment or treatment. Wespath's Notice of Privacy Practices describes the Plan's privacy practices and your rights to access your records. The notice is available on the website, **wespath.org**.

Wespath will require your written authorization before disclosing your PHI to anyone other than you or your personal representative (that is, your guardian or named representative in a power of attorney). You may be asked to fill out and return authorization forms and to provide verification of information. Please remember that these and other actions are taken to safeguard the privacy of you and your family. Also, keep in mind that from time to time employees and agents of Wespath, such as the Claims Administrator, may access PHI, subject to the rules of HIPAA and the privacy policies of Wespath, as part of their day-to-day function of administering the Plan.

Your Responsibility to Provide Accurate Information

The Plan Administrator and Claims Administrator rely on information provided by you when evaluating coverage and benefits under the Plan. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of a Claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Questions

If you have questions about the benefit plans administered by Wespath, please do not hesitate to contact us. Wespath welcomes you to HealthFlex and looks forward to serving you.

For more information, please visit our website at **wespath.org**. Or you may call the Wespath Health Team at **1-800-851-2201**.

The Schedule

The Schedule is a brief outline of your benefits payable under the Plan. For a full description of each benefit, refer to the appropriate section listed in the *Table of Contents*.

Plan Document Controls

If any discrepancy exists between this Benefit Booklet and the terms and conditions set forth in the official plan document of the Hospitalizations and Medical Expense Program (Plan Document) or the summary plan description (SPD), the terms of the Plan Document and SPD shall govern.

Eligibility

If you are appointed to or work for a Plan Sponsor of HealthFlex, you may be eligible for coverage under the Plan. Your eligibility depends on the rules of the Plan and the choices of your Plan Sponsor. Contact your Plan Sponsor or Wespath if you have questions about your eligibility under the Plan. For more information about the HealthFlex eligibility rules, please refer to the *HealthFlex Summary Plan Description*, or contact your Plan Sponsor or Wespath.

Cafeteria Plan Rules

For information about the cafeteria plan portion of HealthFlex and the rules that govern the cafeteria plan, including the rules about your ability to make elections under HealthFlex, under §125 of the Code, please refer to the ***HealthFlex Summary Plan Description*** or contact your Plan Sponsor or Wespath.

Through the cafeteria plan, you may pay the portion of the Required Contribution (premium) that is your responsibility as Employee on a tax-advantaged basis, and your Plan Sponsor may also offer flexible spending accounts (FSAs) for medical expenses and dependent care. FSAs can help you pay for medical expenses not covered under the Plan (i.e., Co-payments, Deductibles, dependent care and other exclusions, on a tax-advantaged basis). You can ask your Plan Sponsor about the availability of an FSA.

Important Notices

NOTICE OF FEDERAL REQUIREMENTS

Coverage for Reconstructive Surgery Following Mastectomy
When a Participant who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same Co-payment, Co-insurance and Deductibles that apply to other Plan benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Treatment of physical complications in all stages of mastectomy, including lymph edema; and
- Mastectomy bras and external prostheses limited to the lowest-cost alternative available that meets the patient's physical needs.

The coverage described above is consistent with the requirements of the Women's Health and Cancer Rights Act of 1998 (Cancer Rights Act). Though the Cancer Rights Act is not directly applicable to the Plan because it is a Church Plan, the benefits described above are available to Participants.

If you have any questions about your benefits under this Plan, please call the toll-free number on the back of your ID Card.

Statement of Rights Under the Newborns and Mothers' Health Protection Act
Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending Provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Notice of Patient Protections
The Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the HealthFlex Plan's network, i.e., is an In-Network Provider that is a primary care Provider, and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider and for a list of the In-Network Providers who are primary care Providers, you can access Blue Cross and Blue Shield of Illinois' website at **bcbsil.com** or by selecting BlueCross BlueShield from the HealthFlex/WebMD website.

You do not need prior authorization from HealthFlex or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The Provider you choose, however, may be required to comply with certain procedures, including obtaining prior

authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of In-Network Providers who specialize in obstetrics or gynecology, you can access Blue Cross and Blue Shield of Illinois at **bcbsil.com** or by selecting BlueCross BlueShield from the HealthFlex/WebMD website.

Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment with respect to military leaves of absence. These requirements may apply to medical coverage for you and your Dependents. They do not apply to any life, short-term or long-term disability or accidental death and dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the *Termination of Coverage* section regarding leave of absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

- You may continue benefits, by paying the required contribution to your employer or Plan Sponsor, as applicable, until the earliest of the following:
  - For a period of time as determined by your employer or Plan Sponsor from the last day of employment with the employer or Plan Sponsor;
  - The day after you fail to apply or return to work; or
  - The date the Plan is terminated.
- The Plan may charge you and your Dependents up to 102% of the total required contribution.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect continuation coverage and you are re-employed by your current employer or Plan Sponsor, coverage for you and your Dependents may be reinstated if: a) you gave your employer or Plan Sponsor advance written or verbal notice of your military service leave, and b) the duration of all military leaves while you are employed with your current employer or Plan Sponsor does not exceed five years.

Time Frames for Requesting Re-employment

When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your employer or Plan Sponsor by the next regularly scheduled work day following eight hours of travel time;
- For leaves of 31 to 180 days, by submitting an application to your employer or Plan Sponsor within 14 days; and
- For leaves of more than 180 days, by submitting an application to your employer or Plan Sponsor within 90 days.

Consult your employer or Plan Sponsor for more details regarding your rights and your employer or Plan Sponsor's obligations for re-employment.

Claims

How to File a Medical or Behavioral Health Claim

In order to obtain your medical and behavioral health benefits under this Plan, it is necessary for a Claim to be filed with the Claims Administrator. To file a Claim, usually all you will have to do is show your ID Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claims Administrator.

Once the Claims Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid; this is called an Explanation of Benefits (EOB). In some cases the Claims Administrator will send the payment directly to you or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claims Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving Services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

- Complete a Claim form. These are available from your Plan Sponsor, Wespath or from the Claims Administrator's office or website.
- Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service, and a description of the service and the Claim Charge.
- Mail the completed Claim form with attachments to:

  Blue Cross and Blue Shield of Illinois
  P. O. Box 805107
  Chicago, Illinois 60680-4112

Claims must be filed no later than 12 months after the date a service is received. Claims not filed within 12 months from the date a service is received may not be eligible for payment, or will be subject to reduced payment.

If you have any questions about filing Claims, contact Wespath or call the Claims Administrator's office.

Claims Procedures

The Claims Administrator will pay Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claims Administrator does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claims Administrator

will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see *Payment of Claims and Assignment of Benefits* provisions in the Information and Records section of this Benefit Booklet).

If the Claim is denied in whole or in part, you will receive a notice from the Claims Administrator with:

- The reasons for denial,
- A reference to the Plan provisions on which the denial is based,
- A description of additional information which may be necessary to perfect the Claim, and
- An explanation of how you may have the Claim reviewed by the Claims Administrator if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690-1364

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. While the Claims Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. For claims where services have already been provided, the Claims Administrator will give you a written decision within 60 days after it receives your request for review. For claims that have been denied before services have been rendered, the Claims Administrator will give you a written decision within 15 days if the claim was medically denied and within 30 days if the claim was contractually denied).

In accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA), you have additional rights to appeal claims because the Plan is not a "grandfathered plan." The Claims Administrator will follow the terms of the PPACA and the regulations issued by the Department of Health and Human Services implementing the PPACA regarding claims, appeals and external reviews.

If the Claims Administrator has denied your Claim for Benefits in whole or in part for a requested treatment or service, or rescinded your coverage, then you will receive a notice of adverse benefit determination. Subject to privacy laws and other restrictions, if any, the Claims Administrator will make available to you certain information including, for example, the date of service, health care provider, diagnosis, treatment and denial codes with their meanings along with the reason for denial.

If, at any time, you need assistance with the internal claims and appeals or external review processes, you may contact the health insurance consumer assistance office or ombudsman established by the Department of Health and Human Services (HHS). You may check the HHS website (**www.hhs.gov**) or call the phone number on the back of your ID Card for contact information.

Claims Process and Additional Internal Appeal Rights under the PPACA
For urgent care claims, the Claims Administrator will notify you regarding claims benefit determinations not later than 24 hours after the receipt of your claim, unless you fail to provide sufficient information. The Claims Administrator will notify you of the missing information and you will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received. You have the option of presenting evidence and testimony to the Claims Administrator in writing, by phone or in person at a designated location. Please reference the address and phone number information below. The Claims Administrator will provide you with any new or additional evidence or rationale and any other information and documents used in the adverse benefit determination so you have a reasonable opportunity to respond before a final decision is made. You have 180 days from the date you receive notice of the adverse benefit determination to file an internal appeal, and the Claims Administrator's appeal decision will be sent to you within 60 days of receipt of your appeal request.

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690-1364
1-877-284-9302

For additional information about eligibility-related denials or a rescission decision, please reference the address and phone numbers below.

Blue Cross Blue Shield
P.O. Box 3235
Naperville, IL 60566-7235
Customer Service: 1-800-538-8833

External Review Process
You must file your request for external review within 4 months after receiving notice from the Claims Administrator of an adverse benefit determination or final internal adverse benefit determination. The Claims Administrator will complete a preliminary review of your request within 5 business days to determine whether you are eligible for external review. You may be required to exhaust the

internal appeal process (described above) before being eligible for external review. You will be notified within 1 business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period to complete the appeal request. If your Claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice and will provide contact information for the Employee Benefits Security Administration. Once an eligible request for external review is complete, the Claims Administrator will assign the matter to an independent review organization (IRO). The assigned IRO will be independent, unbiased, randomly selected entity that receives no financial incentive based on the outcome of any review. There will be no charge to you for the IRO review. The acknowledgement of receipt of your request from the IRO will contain additional information about its review process, the types of additional information that you can submit for review and the information that must be included in the decision of the IRO. You should note that the IRO is not bound by the adverse or final adverse benefit determination of the Claims Administrator. The IRO will retain appropriate clinical and legal consultants to conduct the review and issue a letter fully explaining its decision within 45 days after receipt of an eligible request for external review. The decision of the IRO is binding on the parties, but there may be additional state or federal remedies available. If the IRO reverses the adverse or final adverse benefit determination, the Claims Administrator will immediately provide coverage or payment for the Claim.

Expedited external review: You may seek expedited external review in certain circumstances where any delay in issuing a benefit determination would seriously jeopardize your life, health or your ability to regain maximum function or your claim involves emergency treatment and you have not been released from the treating facility. Upon receipt of the request for expedited external review, we must immediately notify you whether the request is complete and eligible for external review. If the claim is eligible for an expedited external review, we will assign the claim to an IRO and provide the IRO with all relevant information electronically, by phone, fax, or by other expeditious means. The IRO's process will be equivalent to a standard review, but must be completed as quickly as circumstances require but no later than 72 hours after the IRO receives the review request.

If you have any questions about the Claims Procedures or the review procedure, write or call the Claims Administrator headquarters. The Claims Administrator offices are open from 8:45 a.m. to 4:45 p.m. Central time, Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 E. Randolph St.
Chicago, IL 60601

If you filed a Claim for benefits and have asked the Claims Administrator to review your Claim (if it was initially denied, in whole or in part) and your Claim has been denied, in whole or in part, upon request for review, you may file suit in state or federal court—only after you have exhausted these administrative remedies.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Note: The preceding Claims procedures apply only to Claims for medical and behavioral health benefits under the Plan. The Claims procedures for Prescription Drug benefits are described in the *Prescription Drugs Benefits* section of this Benefit Booklet.

Eligibility Claims: If the Plan Administrator (Wespath) has denied or limited your Claim for eligibility or rescinded your coverage, then you will receive a notice of adverse benefit determination. Wespath will make available to you certain information including the reason for denial. For information about the Claim review procedures and appeal process for eligibility Claims, please review the ***HealthFlex Summary Plan Description***.

Important Information About Your Plan

YOUR ID CARD

You will receive an identification card (ID Card). This card will tell you your identification number and will be very important to you in obtaining your benefits.

HEALTH REIMBURSEMENT ACCOUNTS

Your medical plan may include a health reimbursement account (HRA). HRA plans allow you as a Participant to use a Health Reimbursement Account (HRA), explained below, to pay certain health care expenses directly, while a plan with a higher deductible, protects you from high cost medical expenses.

The HRA is a health reimbursement arrangement, as described in *IRS Notice 2002-45*, used to offset eligible unreimbursed expenses incurred by the Participant or covered eligible Dependents. Contributions to the HRA from the Plan and your Plan Sponsor generally are not taxable. You cannot make any contributions to an HRA. If you do not use all your HRA funds during a Plan Year (calendar year), the remaining amount will roll over to the following Plan Year, with no limit on accumulated rolled-over funds in your HRA.

HRA balances remaining in your account at the time you retire may be converted to a Retiree HRA and used to the extent allowed under the law for eligible health care-related expenses, including retirement health coverage outside of HealthFlex. To be eligible, however, you must satisfy the retiree eligibility rules for health coverage in retirement of both the HealthFlex Plan (which are explained in detail in the *HealthFlex Summary Plan Description*) and those established by your Plan Sponsor (i.e., your Conference or employer). Your HRA balance generally will be available for your use even if your Plan Sponsor does not sponsor retiree health coverage through HealthFlex.

For additional information about the HRA Plans and HRAs, refer to the ***HealthFlex Summary Plan Description*** or contact your Plan Sponsor or Wespath.

HEALTH SAVINGS ACCOUNTS

Your medical plan may include a health savings account (HSA). An HSA plan allows you as a Participant to contribute to a Health Savings Account (HSA), explained below, to pay certain health care expenses directly, while also protecting you from high cost medical expenses.

The HSA is used to offset eligible unreimbursed expenses incurred by the Participant or covered eligible Dependents. Contributions to the HSA from the Plan and your Plan Sponsor, as well as participant contributions, generally are not taxable. If you do not use all your HSA funds during a Plan Year (calendar year), the remaining amount will roll over to the following Plan Year, with no limit on accumulated rolled-over funds in your HSA.

HSA balances remaining in your account at the time you retire can be used to the extent allowed under the law for eligible health care-related expenses, including retirement health coverage outside of HealthFlex.

For additional information about the HSAs and HSA plans, refer to the ***HealthFlex Summary Plan Description***, or contact your Plan Sponsor or Wespath.

OBTAINING YOUR MEDICAL AND BEHAVIORAL HEALTH BENEFITS

The Plan has selected Blue Cross and Blue Shield of Illinois as the administrator of its medical and behavioral health benefits for certain geographic areas. Medical and behavioral health benefits are administered separately from the other components of the Plan, such as Prescription Drug benefits or vision benefits.

Providers in the network of Providers that is available to you through the Claims Administrator have agreed to accept discounted payments for Covered Services, with no additional billing to the Participant other than Co-insurance and Deductible amounts. You may obtain further information about the participating status of Professional Providers and information on Out-of-Pocket expenses by calling the toll-free telephone number on your ID Card.

On the other hand, you should be aware that when you obtain medical or behavioral health services from an Out-of-Network Provider in non-Emergency situations, *you may have to pay more than the Co-insurance amount described in The Schedule after the Plan has paid its required portion.* Out-of-Network Providers may bill Participants for any amount up to the total billed charge after the Plan has paid its portion of the bill.

You will receive the highest possible benefit for health care services when you obtain such services from In-Network Providers (you must present your ID Card at the time of service).

WHEN SERVICES ARE NOT AVAILABLE FROM AN IN-NETWORK PROVIDER

If you must receive Covered Services that the Claims Administrator has reasonably determined are unavailable from an In-Network Provider, benefits for the Covered Services you receive from an Out-of-Network Provider will be provided at the payment level described for an In-Network Provider.

IN-NETWORK PROVIDERS

In-Network Providers are Providers who have signed an agreement with the Claims Administrator to accept the Maximum Allowance as payment in full. Such In-Network Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claims Administrator's benefit payment and the

Maximum Allowance for the particular Covered Service—that is, your Deductible, Co-payment and Co-insurance amounts.

OUT-OF-NETWORK PROVIDERS

Out-of-Network Providers are Providers who have not signed an agreement with the Claims Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claims Administrator's benefit payment and such Provider's charge to you when you use an Out-of-Network Provider.

If you would like to know the Maximum Allowance for a particular procedure or whether a particular Provider is an In-Network Provider, contact your Provider or the Claims Administrator.

LIFETIME MAXIMUM BENEFIT

There is no lifetime dollar limit applied to eligible Benefits payable under the Plan.

CUMULATIVE BENEFIT MAXIMUMS

All benefits payable under this Plan are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service, the Claims Administrator will include benefit payments under both this and any prior or subsequent health care program administered by the Claims Administrator issued to you as an Eligible Person or a Dependent of an Eligible Person under this Plan.

OUT-OF-POCKET MAXIMUMS

There are separate Out-of-Pocket Maximums applicable to Covered Services received from In-Network Providers and Out-of-Network Providers. Out-of-Pocket Maximums will cross-accumulate for In-Network Providers and Out-of-Network Providers. In other words, charges incurred for Covered Services from either In-Network or Out-of-Network Providers will be used to satisfy both the In-Network Provider Deductible and Out-of-Pocket Maximum and the Out-of-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the In-Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Out-of-Network Providers will be used to satisfy the remainder of the Out-of-Network Provider Deductible and Out-of-Pocket Maximum.

BENEFITS FOR MEDICARE-ELIGIBLE COVERED PERSONS

This section describes the benefits that will be provided for Medicare-Eligible Covered Persons for whom Medicare should pay primary, unless otherwise specified in this Benefit Booklet (see provisions titled *Medicare-Eligible Covered Persons* in the *Eligibility* section of this Benefit Booklet and *Medicare Eligibles* in the *Coordination of Benefits* section of this Benefit Booklet).

The benefits and provisions described throughout this Benefit Booklet apply to you; however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits for Medicare-Eligible Covered Persons under the Plan is as follows:

- The Plan will determine what the payment for a Covered Service would be following the payment provisions of this coverage, and
- The Plan will deduct from this resulting amount from the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted *whether or not you have enrolled and/or received payment from Medicare*.) The difference, if any, is the amount that will be paid under the Plan.

When you have a Claim, you must send the Claims Administrator a copy of your Explanation of Medicare Benefits (EOMB) in order for your Claim to be processed. In the event you are eligible for Medicare to pay primary but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used. If Medicare is the Primary Plan for your benefits for a reason listed in the section titled *Medicare Eligibles* in the Coordination of Benefits section of this Benefit Booklet and you would like automated filing of your EOMB so that you do not have to file a separate Claim through submitting a paper form with the Plan, contact Blue Cross and Blue Shield of Illinois customer service at the phone number on your ID Card for further information.

BlueCare Connection Program

The Claims Administrator has established the BlueCare Connection Program® (BCC) to perform a review of certain Covered Services prior to such services being rendered. The BCC is responsible for reviewing admissions to Inpatient facilities, determining Medical Necessity of Inpatient stays, and reviewing admission lengths of stay.

The BCC Program staff is primarily Registered Nurses and other personnel who have clinical backgrounds. Physicians in the Claims Administrator's medical department also play an essential role in the BCC Program. This program helps to ensure that you receive high-quality, cost-effective care when admitted to an Inpatient facility.

Please read the provisions below carefully.

Note: You are required to contact the BCC program in certain situations, as outlined below. Call the toll-free telephone number on your Blue Cross and Blue Shield ID Card to contact the BCC Program.

INPATIENT PRE-ADMISSION AND ADMISSION REVIEWS

Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, you must call the BCC. This call must be made at least 1 business day prior to the Hospital admission.

Pre-admission or Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan, if applicable.

If the proposed Hospital admission or health care services are not Medically Necessary, the situation will be referred to the Claims Administrator's Physician for review. If the Claims Administrator's

Physician concurs that the proposed admission or health care services are not Medically Necessary services for some days or the entire Hospitalization, the Claim will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The BCC will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- Emergency Admission Review: In the event of an Emergency admission, you or someone who calls on your behalf must notify the BCC no later than 2 business days or as soon as reasonably possible after the admission has occurred.
- Maternity Admission Review: In the event of a maternity admission, you or someone who calls on your behalf must notify the MSA no later than 2 business days after the admission has occurred in order to have the Inpatient Hospital admission reviewed.

Even though you are not required to call the BCC *prior to* your maternity admission, if you call the MSA as soon as you find out you are pregnant, the BCC will begin to monitor your case. Call the toll-free telephone number on your Blue Cross and Blue Shield ID Card to contact the BCC Program.

- Other Admissions: Whenever an admission to the following health care Services are recommended by your Physician, you must call the BCC.
  - Skilled Nursing Facility Pre-admission Review: Coordinated Home Care Program Pre-admission
  - Private Duty Nursing Service Review
  - Hospice Care Program

This call must be made at least 1 business day prior to the scheduling of the admission or receiving Services. When you call the BCC, a Case Manager may be assigned to you for the duration of your care. Call the toll-free telephone number on your Blue Cross and Blue Shield ID Card to contact the BCC Program.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan, if any.

Upon completion of the pre-admission or Emergency admission review through the BCC, the BCC will send you a letter confirming that you or your representative called the BCC. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the BCC. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to the Claims Administrator's Physician for review.

MEDICALLY NECESSARY DETERMINATION

As part of its pre-admission review, the BCC can make the decision whether Inpatient care or other health care services or supplies are not Medically Necessary. Should the Claims Administrator's

Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not covered under your benefits. For further details regarding Medically Necessary care and other exclusions from coverage under the Plan, see the sections in this Benefit Booklet titled: *Services Not Covered, Covered Services* and *General Limitations*.

The BCC does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The BCC's determination of Medically Necessary care is limited to merely whether a proposed admission, continued Hospitalization or other health care service is Medically Necessary under the Plan (i.e., whether benefits will be paid by the Plan).

In the event that the Claims Administrator determines that all or any portion of an Inpatient Hospitalization or other health care service is not Medically Necessary, the Claims Administrator will not be responsible for any related Hospital or other health care service charge incurred.

MEDICAL NECESSITY AND YOUR COVERAGE

Remember that your Plan does not cover the cost of Hospitalization or any health care services and supplies that are not considered Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such Hospitalization, service or supply Medically Necessary and does not require the Plan to pay benefits.

Even if your Physician prescribes, orders, recommends, approves or views Hospitalization or other health care services or supplies as Medically Necessary, the Claims Administrator will not pay for the Hospitalization, services or supplies if the BCC and the Claims Administrator's Physician decide they were not Medically Necessary.

BCC PROCESS

When you contact the BCC, you should be prepared to provide the following information:

- The name of the attending and/or admitting Physician,
- The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled,
- The scheduled admission and/or service date, and
- A preliminary diagnosis or reason for the admission and/or service.

When you contact the BCC, the BCC:

- will review the medical information provided and may follow up with the Provider,
- may refer you to an In-Network Provider for service, and
- may determine that the services to be rendered are not Medically Necessary.

In some cases, if your condition requires care in a Hospital or other health care facility, the case manager may recommend an alternate treatment plan.

Alternate treatment benefits will be provided only so long as the Claims Administrator determines that the alternative treatment services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative treatment services shall not exceed the total benefits for which you would otherwise be entitled under the Plan.

Provision of alternative treatment benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative treatment benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Plan.

- You, your Dependent or an attending Physician can request case management services by calling the toll-free number shown on the back of your ID Card during normal business hours, Monday through Friday.
- You or your Dependent may be contacted by an assigned case manager who will explain in detail how the program works. Participation in the program is voluntary—no penalty or benefit reduction is imposed if you do not wish to participate in case management.
- Following an initial assessment, the case manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing Services or a Hospital bed and other Durable Medical Equipment for the home).
- The case manager also acts as a liaison between the Plan, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

BCC APPEAL PROCEDURE

If you or your Physician disagrees with the determination of the BCC prior to or while receiving Services, you may appeal that decision by contacting the BCC or the Claims Administrator's Medical Director.

In some instances, the resolution of the appeal process will not be completed until your admission or Service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the BCC, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation, P. O. Box A3957, Chicago, IL 60601

You must exercise the right to this appeal as a precondition to taking any action against the Claims Administrator or the Plan Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claims Administrator. Additional information and comments must be submitted within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any pertinent documents held by the Claims Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claims Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of such additional time during the initial 30-day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility, and the BCC will not interfere with your relationship with any Provider. However, the Claims Administrator has established the BCC program for the specific purpose of assisting you in determining the course of treatment that will maximize your Plan benefits described in this Benefit Booklet. Failure to notify the BCC when appropriate may prevent you from maximizing your benefit.

MEDICARE-ELIGIBLE PARTICIPANTS

The provisions of this BCC program do not apply to you if you are Medicare-eligible and have secondary coverage provided under the Plan.

Benefit Payment

If you or any one of your Dependents incurs Charges for Covered Services while you are a Participant in the Plan, the Claims Administrator will pay an amount shown in The Schedule.

Payment of any benefits will be subject to: any applicable Co-insurance, Co-payments, Deductibles and Maximum Benefits shown in The Schedule.

Full Payment Area

IN-NETWORK PROVIDER OUT-OF-POCKET MAXIMUM

When a Participant has incurred an amount of Out-of-Pocket Expenses equivalent to the In-Network Provider individual maximum as shown in The Schedule, benefits for that Participant for Covered Services from an In-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

When either (a) you and your Dependents or (b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses equivalent to the In-Network Provider family maximum as shown in The Schedule, benefits for you and all of your Dependents for expenses related to Covered Services from

an In-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

OUT-OF-NETWORK PROVIDER OUT-OF-POCKET MAXIMUM
When a Participant has incurred an amount of Out-of-Pocket Expenses equivalent to the Out-of-Network Provider Individual Maximum as shown in The Schedule, benefits for that Participant for expenses related to Covered Services from an Out-of-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

When either: a) you and your Dependents, or b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses equivalent to the Out-of-Network Provider family maximum as shown in The Schedule, benefits for you and all of your Dependents for expenses related to Covered Services from an Out-of-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

Any benefit Deductible applicable to specific benefits hereunder, if not yet satisfied, will continue to apply until satisfied.

Please note that changes in excess of the Maximum Allowance set by the Claims Administrator are not Covered Services, and are, therefore, not included in the Full Payment Area provision of the Plan.

Eligible Expenses—Covered Services

The term Covered Services means the services listed below for which expenses incurred by or on behalf of an individual will be paid by the Claims Administrator, if the expenses are incurred after he or she becomes covered as a Participant under the Plan. Such services are considered Covered Services, to the extent that the services or supplies provided are recommended by a Physician and Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by the Claims Administrator. Any applicable Co-payments, Co-insurance, Deductibles or maximums are shown in The Schedule.

Covered Services include:

- Investigational services and supplies and all related services and supplies, including the cost of routine patient care associated with investigational cancer treatment provided in connection with an approved clinical trial program.
- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Services will not include that portion of Charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical or behavioral health care and treatment can be provided.
- Transportation by professional ambulance (not including air ambulance) to and from a medical or behavioral health facility.
- Transportation by regularly scheduled airline, railroad or air ambulance to the nearest medical or behavioral health facility qualified to give the required treatment.

- Charges made by a Hospital, on its own behalf, for medical or behavioral health care and treatment received as an Outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
- Charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility on its own behalf, for medical care and treatment; except that Covered Services will *not* include that portion of such Charges which is in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Medically Necessary Prescription Drugs while an individual is confined in a Skilled Nursing Facility.
- Charges made by a Physician or a Psychologist for professional Services.
- Charges made by a Nurse for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; prosthetic appliances; and dressings.
- Charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.
- Charges made for an annual routine mammogram (additional charges for a 3D mammogram may not be covered unless medically necessary).
- Charges made for an annual Papanicolaou laboratory screening test (Pap test).
- Charges made for an annual Prostate-Specific Antigen test (PSA) and a digital rectal exam.
- Charges made for an annual colorectal cancer screening.
- Charges made for annual routine blood work.
- Charges made for intrauterine devices (IUD), including insertion and removal.
- Charges made for Diaphragms.
- Charges made for services to remove, place, or inject covered FDA-approved contraceptive methods (e.g. Norplant).
- Charges made for sterilization procedures for women (e.g. tubal ligation)
- Charges made for visits for routine preventive care of a Dependent child under age 16 including physical examinations, routine diagnostics and immunizations.
- Charges made for visits for routine preventive care of adults age 16 and over including a physical examination, routine diagnostics and immunizations.
- Charges made for Renal Dialysis treatments made by a Hospital, dialysis facility or in your home under the supervision of a Hospital or dialysis facility.
- Charges made for counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.
- Charges made for laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.
- Charges for nutritional formulae when required for:
  - the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
  - enteral feeding for which the nutritional formulae under state or federal law can be

dispensed only through a Physician's prescription and are Medically Necessary as the primary source of nutrition.

- Charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.
- Charges made by a Hospital for maternity coverage, including coverage for mother and child for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Coverage for the newborn will terminate on the last day of the month in which the child is 31 days old and only cover routine newborn services unless the child is added to coverage. More time may be covered if deemed Medically Necessary. Maternity coverage will also apply to Dependents who become pregnant.
- Charges for diagnosing, monitoring and controlling inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism.
- Charges made for the examination and testing of an assault victim to establish:
  – that sexual contact did or did not occur; and
  – the presence or absence of sexually transmitted disease or infection. Coverage will also include Charges made for the examination and treatment of injuries and trauma.
- Charges for Inpatient care following a mastectomy. The length of stay is to be determined by the attending Physician after evaluation of the patient. A post-discharge Physician's office visit will be covered within the first 48 hours after discharge from the Hospital, and home health care services will be provided when Medically Necessary. Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. The Plan provides other services under the Women's Health and Cancer Rights Act, including breast prostheses and treatment of complications, in the same manner and at the same level as those for any Covered Service.
- Charges for family planning services including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, other medical services, information and counseling on contraception including implanted/injected contraceptives. Office visits, tests and counseling are subject to any Preventive Care Maximum shown in The Schedule.
- Charges for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity will be Covered Services if such condition meets the definition set out in the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines in the view and discretion of the Claims Administrator and Plan Administrator and if the services are demonstrated, through peer-reviewed medical literature and scientifically-based guidelines, to be safe and effective for treatment of the condition.
- Charges for telemedicine services provided by the HealthFlex preferred telemedicine provider (MD LIVE), limited to one visit per 24 hours per individual.
- Transsexual Surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such Surgery.
- Charges for Medically Necessary eye exams (required due to other medical conditions, such as diabetes)

- Dental Accident Care and Limited Dental Surgery Care
  - Charges made for dental services rendered by a dentist or Physician that are required as the result of an accidental injury.
  - Surgery benefits are limited to the following dental services:
    - Surgical removal of complete bony impacted teeth;
    - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
    - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses), treatment of fractures of facial bone, external incision and drainage of cellulites, incision of accessory sinuses, salivary glands or ducts and reduction of dislocation of, or excision of the temporomandibular joints.

The following benefits will be Covered Services for insulin-dependent and non-insulin-dependent diabetics as well as Covered Persons who have elevated blood sugar levels due to pregnancy or other medical conditions:

- Charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances related to diabetes.
- Charges for insulin, syringes, prefilled insulin cartridges for the blind, oral blood sugar control agents, glucose test strips, visual reading ketone strips, urine test strips, lancets and alcohol swabs, when dispensed by Physician or home health care provider.
- Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed,
  - Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management,
  - Visits when re-education or refresher training is prescribed by the Physician, and
  - Medical nutrition therapy related to diabetes management.

HOME HEALTH SERVICES

Charges made for Home Health Services are Covered Services when you:

- require skilled care,
- are unable to obtain the required care as an ambulatory Outpatient, or
- do not require confinement in a Hospital or Other Health Facility.

Home Health Services are provided only if the Claims Administrator has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), Home Health Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house—even if that person is an Other Health Care Professional. Physical, occupational and other Short-Term Rehabilitative Therapy Services provided in the home are not subject to the Home Health Services benefit limitations in The Schedule, but are subject to the benefit limitations described under the Short-Term Rehabilitative Therapy Maximum shown in The Schedule.

HOSPICE CARE SERVICES

The following Charges are Covered Services when made due to Terminal Illness for the Hospice Care Services provided under a Hospice Care Program:

- Services by a Hospice Facility for Bed and Board and services and supplies, except that, for any day of confinement in a private room, Covered Services will not include that portion of Charges which is more than the Hospice Bed and Board limit shown in The Schedule;
- Charges by a Hospice Facility for Services provided on an Outpatient basis;
- Charges by a Physician for professional services;
- Charges by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
- Pain relief treatment, including drugs, medicines and medical supplies;
- Charges by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of Other Health Care Professional; and
  - physical, occupational and speech therapy, and medical supplies, drugs and medicines lawfully dispensed only on the written prescription of a Physician, and
  - laboratory services, but only to the extent that such Charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following Charges for Hospice Care Services are ***not*** included as Covered Services:

- The Services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house,
- Any period when you or your Dependent is not under the care of a Physician,
- Services or supplies not listed in the Hospice Care Program,
- Any curative or life-prolonging procedures,
- To the extent that any other benefits are payable for those expenses under the Plan, and for Services or supplies that are primarily to aid you or your Dependent in daily living.

DURABLE MEDICAL EQUIPMENT

Charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed and provided by a vendor approved by the Claims Administrator for use outside a Hospital or Other Health Care Facility are Covered Services. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of Durable Medical Equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Participant's misuse are the Participant's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, wheel chairs, and dialysis machines.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Benefits are provided for the replacement of a type of Durable Medical Equipment once every 3 calendar years.

Durable Medical Equipment items that are ***not covered***, include, but are not limited to, those that are listed below:

- Bed related items: bed trays, over the bed tables, bed wedges, custom bedroom equipment, non-power mattresses, pillows, posturepedic mattresses, low air mattresses (powered), alternating pressure mattresses.
- Bath related items: bath lifts, nonportable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, spas.
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized-manual hydraulic lifts are covered if the patient is two-person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts customizations).
- Air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Pumps: back packs for portable pumps.
- Other equipment: heat lamps, heating pads, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

EXTERNAL PROSTHETIC APPLIANCES

Covered Services include:

- Charges made for the initial purchase and fitting of external prosthetic devices which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Sickness, Injury or congenital defect.
- External prosthetic devices include: basic limb prosthetics, terminal devices such as hands or hooks, braces and splints, and eligible non-foot orthoses. Only the following non-foot orthoses are covered: a) rigid and semi-rigid custom fabricated orthoses; b) semi-rigid prefabricated and flexible orthoses; c) rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints; and d) FDA-approved cranial orthotic devices for the treatment of non-synostatic positional plagiocephaly. Custom foot orthotics are covered only as follows:
  - For Participants with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
  - When the foot orthotic is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - When the foot orthotic is for use as a replacement or substitute for a missing part of the foot (e.g., amputation) and is necessary for the alleviation or correction of illness, injury or congenital defect;
  - For Participants with neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.
- Wigs (also referred to as cranial prostheses).
- Eyeglasses or contact lenses as a result of cataract surgery.

The following are specifically ***excluded***:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for adjustments, replacement and repair of external prosthetic appliances is provided only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from the Participant's misuse are the Participant's responsibility.

INFERTILITY SERVICES

Charges made for Infertility Services, including services related to the treatment of infertility once a condition of infertility has been diagnosed, are Covered Services. Also, included are services for further diagnosis to determine the cause of infertility.

Infertility Services include, but are not limited to: infertility drugs, including injectable drugs, which are administered or provided by a Physician; Surgeries and other therapeutic procedures; laboratory tests; sperm washing or preparation; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in-vitro fertilization (IVF); uterine embryo lavage; embryo transfer; artificial insemination; zygote intrafallopian transfer (ZIFT); low tubal ovum transfer; and the services of an embryologist. Infertility Services are payable as any other Sickness.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
- you have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be 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.

Special Limitations
This benefit includes diagnosis and treatment of both male and female infertility. However, the following are specifically ***excluded*** Infertility Services:

- A reversal of voluntary sterilization;
- Infertility Services when the infertility is caused by or related to voluntary sterilization;
- Donor Charges and services;
- Any experimental or investigational infertility procedures or therapies;
- Surrogate parenting;
- Fees or direct payment to a donor for maintenance and/or storage of frozen embryos;
- Fetal reduction Surgery; and
- Health services associated with the use of non-surgical or drug-induced pregnancy termination.

SHORT-TERM REHABILITATIVE THERAPY AND MANIPULATIVE THERAPY SERVICES

Charges made for Short-Term Rehabilitative Therapy that is part of a rehabilitation program are Covered Services, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following *limitations* apply to Short-Term Rehabilitative Therapy and Manipulative Therapy Services:

- Services that are considered custodial or educational in nature are ***not covered***.
- Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy, and must indicate the diagnosis and anticipated goals.
- Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy, and must indicate the diagnosis and anticipated goals.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the participant's condition within 2 months of the start of treatment.

Speech therapy is limited to Medically Necessary speech therapy used to improve speech skills that have not fully developed in children due to an underlying disease or malformation. Congenital speech therapy is limited to children from birth to age 3.

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Speech therapy is not covered when such treatment is intended to maintain speech communication or when it is not restorative in nature.

If multiple Outpatient services are provided on the same day they constitute one visit, but a separate Co-payment will apply to the services provided by each Provider.

CHIROPRACTIC CARE

Charges made for Chiropractic Care or services are Covered Services as follows:

- Charges for care are limited to the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function;
- Charges for office examinations including: patient history, physical examination, spinal X-rays, laboratory tests, and neuromuscular treatment and manipulation;
- Charges for lab work; and
- Charges are limited to Medically Necessary care provided in an office setting.

The following Charges are ***excluded***:

- Services of a Chiropractor that are not within the scope of his or her practice as defined by state law,
- Vitamin therapy, and
- Maintenance or Preventive Treatment.

HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions described in this Benefit Booklet. Please refer to the *Services Not Covered* sections of this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Benefit Booklet, the following definitions are applicable to this Benefit Section:

- *Audiologist* means a duly licensed audiologist.
- *Hearing aid dealer* means a Provider licensed to make and provide hearing aids.
- *Otologist* means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period is a period of one year that begins on January 1 of each year. When you first enroll under this coverage, your first benefit period begins on your coverage date, and ends on the first December 31 following that date.

Covered Services for Hearing Care
Benefits will be provided under this Benefit Section for the following:

- Audiometric examination
- Hearing aid evaluation
- Conformity evaluation
- Hearing aids

Benefits will be limited to Covered Service(s) of each type listed above per benefit period.

Special Limitations
Benefits will ***not*** be provided for the following:

- Audiometric examinations by an Audiologist when not ordered by your Physician within six months of such examination.
- Medical or surgical treatment.
- Drugs or other medications.
- Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.
- Hearing aids ordered while covered but delivered more than 60 days after termination.

Benefit Payment for Hearing Care
Benefits for hearing care Covered Services will be provided at the payment level specified in *The Schedule* of this Benefit Booklet.

For purposes of this Hearing Care Program Section only, the definition of Maximum Allowance shall read as follows:

> Maximum Allowance means the amount as reasonably determined by the Claims Administrator, which is based on the fee which the Physician, Otologist, Audiologist or Hearing Aid Dealer who renders the particular service usually Charges his patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

HUMAN ORGAN TRANSPLANTS

Covered Services include your benefits for certain human organ transplants, including, but not limited to cornea, kidney, bone marrow, heart valve, muscular-skeletal and parathyroid—as subject to the facility and surgical benefits as indicated in *The Schedule*.

Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by his or her own plan or program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this Benefit Booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this Benefit Booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor.
- The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claims Administrator by telephone before your transplant Surgery has been scheduled. The Claims Administrator will furnish you with the names of Hospitals which have Claims Administrator-approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claims Administrator-approved Human Organ Transplant Program.
- If you are the recipient of the transplant, benefits will be provided for transportation, lodging and meals for you and a companion. If the recipient of the transplant is a Dependent child under the limiting age of this Benefit Booklet, benefits for transportation, lodging and meals will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- You and your companion are each entitled to benefits for lodging and meals up to a combined maximum of $200 per day.
- Benefits for transportation, lodging and meals are limited to a maximum of $10,000 per transplant.

In addition to the other exclusions of this Benefit Booklet, benefits will ***not*** be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant surgery.
- Travel time and related expenses required by a Provider.
- Drugs that do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

BREAST RECONSTRUCTION AND BREAST PROSTHESES

Charges made for reconstructive Surgery following a mastectomy; benefits include:

- Surgical services for reconstruction of the breast on which Surgery was performed;
- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- Postoperative breast prostheses; and
- Mastectomy bras and external prosthetics, limited to the lowest-cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are Covered Services.

RECONSTRUCTIVE SURGERY

Charges made for reconstructive Surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw related to TMJ disorder) provided that:

- The surgery or therapy restores or improves function;
- Reconstruction is required as a result of Medically Necessary, non-cosmetic Surgery;
- The Surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to microtia, amastia and Poland Syndrome.

Repeat or subsequent Surgeries for the same condition are Covered Services only when there is the probability of significant additional improvement, as determined the Claims Administrator.

WOMEN'S PREVENTIVE SERVICES

The following preventive services for women are Covered Services with no co-payment, co-insurance or deductibles:

- Well-woman visits
- Sexually transmitted infections counseling and HIV screening
- Domestic violence screening and counseling
- Human Papillomavirus testing
- Contraception methods and counseling
- Gestational diabetes screening
- Breastfeeding support, supplies and counseling

BEHAVIORAL HEALTH SERVICES

Behavioral health benefits are available only if all of the following are true:

- Covered Behavioral Health Services are received while coverage under the Plan is in effect.
- The person who receives Covered Behavioral Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Please note: In listing services or examples, the term "this includes" is not intended to limit the description to that specific list. Alternatively, the term "is limited to" is used to indicate a list of services or examples that are intentionally limited to specific coverage parameters.

Mental Health and Substance Use Disorder Services

Mental Health Services and Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient
- Residential Treatment Facility
- Partial Hospitalization/Day Treatment
- Intensive Outpatient treatment
- Outpatient Treatment

Services may include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
  - Medication management and other somatic treatments
  - Individual, family, and group therapy
  - Provider-based case management services
- Bereavement Counseling
- Crisis intervention

- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, personality disorders (including dialectical behavior therapy for Borderline Personality Disorders) and paraphilic disorder
- Behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA)) that are the following:
  - Behavioral services for Autism Spectrum Disorder [including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA)] that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder
  - Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under appropriate supervision
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning

Benefits under this section include Mental Health Services for the treatment of a Serious Mental Illness received on an inpatient basis in a Hospital or an Alternate Facility.

BCBS, who will authorize the services, will determine coverage for all levels of care. If an Inpatient stay is required, it is covered on a semi-private room basis.

Services Not Covered

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Clinician or other provider.
- It is the only available treatment for your condition.

The following are ***not*** Covered Services:

1. Hospitalization services and supplies that are *not Medically Necessary*.
   No benefits will be provided for services that are not, in the reasonable judgment of the Claims Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claims Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

   Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claims Administrator, the medical or behavioral health services provided did not require an acute Hospital Inpatient (overnight) setting, 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.

   Examples of Hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting (e.g., a Physician's office or Hospital Outpatient department).
- Hospital admissions primarily for diagnostic studies (X–ray, laboratory and pathological Services and machine diagnostic tests) that could have been provided safely and adequately in some other setting (e.g., Hospital Outpatient department or Physician's office).
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private-duty Nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples—not an exhaustive list—of Hospitalizations or other services and supplies that are not Medically Necessary.

The Claims Administrator will make the decision whether Hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of the Plan. In most instances this decision is made by the Claims Administrator *after you have been Hospitalized or have received other health care services or supplies and after a Claim for payment has been submitted*.

If your claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claims Administrator's decision, the Plan provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to taking any further action against the Claims Administrator or Plan Administrator, either at law or in equity. To initiate your appeal, you must give the Claims Administrator written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, IL 60690

You or your representative may furnish or submit any additional documentation that you or your Physician believe appropriate.

Note: Even if your Physician prescribes, orders, recommends, approves or views Hospitalization or other health care services and supplies as Medically Necessary, the Claims Administrator, and therefore the

Plan, will not pay for the Hospitalization, services and supplies if it decides such services or hospitalization were not Medically Necessary.

2. Services or supplies that are not specifically mentioned in this Benefit Booklet.
3. Services or supplies for any Sickness or Injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws, whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
4. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (e.g., Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 w 1–1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
5. Services and supplies for any Sickness or Injury occurring on or after your coverage date as a result of war or an act of war.
6. Services or supplies that do not meet accepted standards of medical, behavioral health, and/or dental practice.
7. Custodial Care Service.
8. Long-term care service.
9. Respite Care Service, except as specifically mentioned under the Hospice Program.
10. Inpatient Private Duty Nursing Service.
11. Cosmetic surgery or therapy and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. Cosmetic Surgery or therapy is defined as Surgery or therapy performed to improve appearance or self-esteem.
12. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
13. Charges for failure to keep a scheduled visit or Charges for completion of a Claim Form.
14. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
15. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Benefit Booklet.
16. Blood derivatives that are not classified as drugs in the official formularies.
17. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Benefit Booklet.
18. Treatment of flat foot conditions and the prescription of supportive devices for such conditions, and the treatment of subluxations of the foot.
19. Routine foot care, except for persons diagnosed with diabetes.

20. Immunizations, unless otherwise specified in this Benefit Booklet.
21. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
22. Maintenance Care.
23. Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or cognitive impairment/delay.
24. Services and supplies to the extent benefits are duplicated because the Spouse, parent and/or child are covered separately under this Plan.
25. Premarital examinations, determination of the refractive errors of the eyes, determination of auditory problems, surveys, case-finding, research studies, screening, or similar procedures and studies, or tests which are investigational, unless otherwise specified in this Benefit Booklet.
26. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
27. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Benefit Booklet.
28. Elective abortions.
29. Replacement of external prostheses due to loss, theft or destruction; or expenses for any biomechanical external prosthetic devices.
30. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
31. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
32. Therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
33. Treatment by acupuncture except as outlined in the Alternative Therapy benefit.38. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
34. Court-ordered treatment or Hospitalization, unless such treatment is prescribed by a Physician and listed under the *Covered Services* section of this Benefit Booklet.
35. Non-medical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or cognitive impairment/delay.
36. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the *Home Health Services* or *Breast Reconstruction and Breast Prostheses* sections of *Covered Services*.

37. Private Hospital rooms and/or Private Duty Nursing unless determined by the Claims Administrator to be Medically Necessary.
38. Membership costs or fees associated with health clubs, weight loss programs (whether or not they are under medical supervision) and smoking cessation programs. Weight loss programs for medical reasons are also excluded. Other excluded expenses include services received from a personal trainer; physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
39. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
40. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Claims Administrator for the purpose of making treatment decisions.
41. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Claims Administrator's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to Surgery.
42. Blood administration for the purpose of general improvement in physical condition.
43. Costs of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
44. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription, and are Medically Necessary as the primary source of nutrition.
45. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
46. Orthognathic treatment/Surgery, including but not limited to treatment/Surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, Surgical augmentation for orthodontics, or maxillary constriction.
47. All noninjectable Prescription Drugs, nonprescription drugs, and investigational and experimental drugs.
48. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
49. Liposuction.
50. Respite Care Service.
51. Experimental or Investigational Services and Unproven Services. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
52. Cosmetic Procedures. See the definition in *Definitions*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Covered Services*.

53. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other Provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

    Note: This exclusion does not apply to mammography testing.
54. Health services for organ and tissue transplants, except those described in *Covered Services*.
55. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan).
56. Health services for transplants involving mechanical or animal organs.
57. Any multiple organ transplant not listed as a Covered Service under the heading Human Organ Transplants, unless determined by MSA to be a proven procedure for the involved diagnoses.
58. Health services provided in a foreign country, unless required as Emergency health services.
59. Travel or transportation expenses, even though prescribed by a Physician.
60. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
61. Growth hormone therapy.
62. Rest cures.
63. Psychosurgery.
64. Treatment of benign gynecomastia (abnormal breast enlargement in males).
65. Medical and surgical treatment of excessive sweating (hyperhidrosis).
66. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
67. Appliances for snoring.
68. Any Charges for missed appointments, room or facility reservations, completion of Claim forms or record processing.
69. Any Charges higher than the actual charge. The actual charge is defined as the Provider's lowest routine charge for the service, supply or equipment.
70. Any Charge for services, supplies or equipment advertised by the Provider as free.
71. Any Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
72. Any Charges prohibited by federal anti-kickback or self-referral statutes.
73. Chelation therapy, except to treat heavy metal poisoning.

74. Any Charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
75. Megavitamin and nutrition-based therapy.
76. Except as described in *Covered Services,* nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs.

Creditable Coverage and Waiting Periods

Pre-existing Condition Waiting Period

Effective January 1, 2014, pre-existing condition exclusions no longer apply to individuals.

Prescription Drug Benefits

OptumRx is the Claims Administrator for all Prescription Drug benefit claims under the Plan. Do ***not*** send Claims for Prescription Drug benefits to Blue Cross and Blue Shield of Illinois (BCBSIL, the Claims Administrator for medical and behavioral health benefits). Please contact your Plan Sponsor or Wespath if you have any questions about to whom you should submit a Claim for your Prescription Drug or medical/behavioral health benefits. Please review this section carefully for information about Prescription Drug benefits under the Plan.

Obtaining Your Prescription Drugs

The Plan has selected OptumRx as the administrator of its Prescription Drug benefits. Prescription Drug benefits are administered separately from the other components of the Plan, such as medical and behavioral health benefits. There are three ways to fill your prescriptions. You can use: 1) one of the 55,000 Participating Retail Pharmacies nationwide, 2) the OptumRx Home Delivery program (the mail-order pharmacy for long-term needs), or 3) a Walgreens Retail Pharmacy for 90-day fills of maintenance medications. You will receive the highest possible benefit for Prescription Drugs when you purchase medications at a Participating Retail Pharmacy (you must present your ID Card) or through OptumRx Home Delivery.

Additional information about your Prescription Drug benefits, including the location of Participating Retail Pharmacies in your area, is available through OptumRx by telephone at **1-855-239-8471.** You also can access the OptumRx website through the HealthFlex/WebMD portal. Go to **wespath.org**, click on "**HealthFlex/WebMD**" and enter your WebMD username and password. Then select "**OptumRx**" under the HealthFlex Vendor Links heading.

You must present your Blue Cross and Blue Shield of Illinois ID Card when receiving Prescription Drugs and services from a Participating Retail Pharmacy. The In-Network Pharmacy will verify your eligibility. You will be required to pay any applicable Deductibles, Co-insurance or Co-payments at the time the prescription is obtained based on the negotiated (discounted) price of the prescriptions, which might include fees that are separately broken out and charged as part of the discounted cost of the medication. The Pharmacist may notify you if a Generic Drug is available; however, it is in your best interest to also ask the Pharmacist about Generic Drug equivalents that may be available. To obtain maximum benefits for Prescription Drugs, you should usually choose Tier 1 (Generic) Drugs, when available.

PRESCRIPTION DRUG FORMULARY

OptumRx utilizes a Formulary management program designed to control costs for you and the Plan. The Formulary includes U.S. Food and Drug Administration (FDA)-approved Prescription Drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. All HealthFlex plans use the OptumRx Premium Formulary. Generally, Tier 1 includes Generic Drugs; Tier 2 includes Formulary Brand-Name Drugs; and Tier 3 includes Non-Formulary Brand-Name Drugs and non-sedating antihistamines except for the generic Fexofenadine. The Premium Formulary excludes the coverage of some brand-name medications that do not offer a clear clinical advantage over other less costly brand or generic alternatives. Medications excluded from the formulary may be reviewed for an exception if deemed medically necessary. You should share the Formulary listing with your Physician or practitioner, and encourage the Physician or practitioner to prescribe one of the Formulary products in order to potentially decrease your Out-of-Pocket Expenses. While currently FDA-approved Prescription Drugs are included on the Formulary list, the Plan may elect to exclude some drugs. Please review the provisions of your Plan for specific drug exclusions. See *Drugs Covered* and *Drugs Not Covered* in this section for further information.

It is always up to you and your Physician to decide which prescription drugs are best for you. You are never required to use Generic Drugs or Brand-Name Drugs that are on the OptumRx Formulary list. If you prefer, you can use Non-formulary Brand-Name Drugs and simply pay a higher Co-payment. You can use Excluded Drugs and pay the cost out of pocket. It is important to note that the Formulary list is routinely updated. To find the most up-to-date list of Covered Prescription Drugs or Preferred Formulary Drugs to share with your Physician, visit the OptumRx website through the HealthFlex/WebMD website, or call the OptumRx member services department at **1-855-239-8471**. It is also important to note that *not all drugs listed on the Formulary are covered due to Plan exclusions and limitations.* Please review the provisions of your Plan for specific exclusions. See the sections called *Drugs Covered, Drugs Not Covered,* and *General Limitations* for more information.

GENERIC MEDICATIONS AND GENERIC FIRST REQUIREMENT

Generic medications may have unfamiliar names, but they are safe and effective. Generic medications and their Brand-Name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic Drugs may differ in color, size or shape, but the FDA requires that the active ingredients have the same strength, purity and quality as their Brand-Name counterparts. For this reason, the Plan will cover only the cost of the Generic Drug equivalent if you purchase a Brand-Name Drug when there is an equivalent Generic Drug available. If you and your Physician choose a Brand-Name Drug when there is an equivalent Generic Drug available, you will be charged one amount equal to the applicable Generic Drug Co-payment (e.g., $15 or 20% of the drug cost, depending on your plan design) plus the cost difference between the Brand-Name Drug and the Generic Drug.

If you have questions or concerns about generic medication, speak to your Physician or your Pharmacist, and he or she will be able to help you. You may also call the OptumRx member service number at **1-855-239-8471** to speak with a registered Pharmacist.

DRUGS COVERED

This section is intended to provide a general description of covered Prescription Drugs and supplies under the Plan at Participating Retail Pharmacies or the OptumRx Home Delivery program. Generally, when you incur a Charge from a Pharmacy for Medically Necessary Prescription Drugs ordered by a Physician or a licensed dentist (for prevention of infection or pain associated with an intensive procedure), the Plan will pay that portion of the Charge remaining after you have met your Deductible and paid any applicable Co-payment. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this Plan. The following are examples of drugs covered under the Plan. This list is periodically reviewed and revised, and the content of this list may change from time to time.

Covered Prescription Drugs include:

- Federal legend drugs, i.e., all drugs approved by the FDA and that require a prescription, except those listed under *Drugs Not Covered* in this section.
- State-restricted drugs.
- Compounded medications of which at least one is a legend drug (restrictions apply to bulk chemicals and must be filled at an approved pharmacy).
- Insulin.
- Needles and syringes.
- Over-the-counter diabetic supplies (except for monitors and Glucowatch products).
- Oral, transdermal, intravaginal, and injectable contraceptives [except drugs that induce abortion (e.g. RDU-486 also known as Mifeprex)].
- Diaphragms and cervical caps.
- Inhaler assisting devices.
- Non-sedating antihistamine Brand-Name Drugs — paid as Tier 3, regardless of the drug's Formulary status. This is a result of the drugs Claritin and Zyrtec being available over-the-counter. The non-sedating antihistamine Generic Drug Fexofenadine is covered as other Generic Drugs under the Plan.
- Prescription smoking cessation products (Plan covers two cycles per year of each active ingredient. When nicotine is the active ingredient, the Plan covers a 180-day supply once per year).
- Emergency Contraceptives (e.g. Plan B, Ella)

DRUGS NOT COVERED

The Plan will ***not*** provide benefits for certain items listed in this section, regardless of medical necessity or a prescription from a health care Provider. However, certain preventive items noted below may be covered with a prescription. The following list of Drugs *not covered* by the Plan is reviewed periodically and may change from time to time.

- Drugs not on the federal legend.
- Non-systemic contraceptives or devices.
- Drugs to treat impotency for females or for males age 17 or younger.
- Differin for individuals older than 34.
- Homeopathics.
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or governmental agency.

- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual.
- Any prescription refilled in excess of the number of refills specified by the Physician or practitioner, or any refill dispensed after 1 year from the Physician's or practitioner's original order.
- Drugs labeled "Caution: Limited by federal law to investigational use" or other experimental or investigational drugs, even though a charge is made to the individual.
- Drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication, other than insulin. However, if a drug within this category is prescribed and is recommended by the United States Preventive Services Task Force (USPSTF) with an 'A' or 'B' grade, it will be covered.
- FDA-approved Prescription Drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications.
- Norplant and other implantable contraceptive devices and products.
  Note: Norplant and other implantable contraceptive devices are covered under the Medical benefits.
- Prescription vitamins (other than prenatal vitamins, injectable vitamin B-12 and injectable vitamin D) and dietary supplements. However, if a drug within this category is prescribed and is recommended by the United States Preventive Services Task Force (USPSTF) with an 'A' or 'B' grade, it will be covered.
- Any Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth (e.g., Rogaine or Propecia), as well as drugs used to control perspiration and fade cream products (e.g., Renova or Vaniqa).
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma, and other blood products or fractions, and medications used for travel prophylaxis.
- Medications used to enhance athletic performance.
- Medications which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals. These medications are generally covered under the medical benefits portion of the Plan through Blue Cross and Blue Shield.
- Prescriptions obtained from a mail-order pharmacy that is not a part of the OptumRx Home Delivery program.
- Topical dental fluorides or other medications to treat dental conditions, which may be covered under the dental benefit.
- Mifeprex.
- Drugs not approved by the FDA, such as those to treat impotency for females only.
- Yohimbine.

- Charges for the administration or injection of any Drug.
- Compounds made with bulk chemicals or from a non-approved compounding pharmacy.

Please note: Seasonale and other drugs packaged in 90- or 91-day supplies purchased at a Retail Pharmacy are covered with a Co-payment equal to three times the standard Retail Pharmacy Co-payment. Other drugs that are pre-packaged by the manufacturer in quantities greater than that covered by the Plan for Retail Pharmacy purchase will be assigned a Co-payment proportional to the total days-supply in the package.

- Mifepristone (RU-486)
- Excluded drugs as detailed in the OptumRx Premium Formulary (other drugs in the same class will be available)

Other limitations are described in the *General Limitations* section.

OPTUMRX SPECIALTY PHARMACY

Specialty Care Pharmacy is the term used to describe certain Prescription Drugs and a set of services designed to meet the particular needs of people who take medications to treat certain conditions such as anemia/neutropenia, cancer, cystic fibrosis, deep vein thrombosis, Gaucher's disease, growth hormone deficiency, hepatitis C, immune deficiency, erectile dysfunction, infertility, multiple sclerosis, osteoarthritis, rheumatoid arthritis and respiratory syncytial virus (RSV). Many of these Prescription Drugs require injection, and have special shipping and handling needs. The OptumRx Specialty Pharmacy service is designed to help you meet the particular needs and challenges of using certain Prescription Drugs as well as allowing HealthFlex to get careful clinical management as well as more favorable pricing for Specialty medications, which are often costly and may require solid adherence in order to be effective. Therefore, the plan requires that certain Specialty medications (as defined by OptumRx) be filled at OptumRx. Fills of the same drug at different Specialty Care Pharmacy or at retail pharmacies will not be covered under HealthFlex and participants will be responsible for paying 100% of the discounted cost of the drug.

The OptumRx Specialty Pharmacy service includes:

- Support from OptumRx nurses and Pharmacists who are trained in specialty Prescription Drugs, their side effects, and the conditions they treat.
- Expedited delivery to your home or your Physician's office for all of your Special Care Prescription Drugs.
- Some supplemental supplies, such as needles and syringes, required to administer the Prescription Drugs, which will be included at no additional charge.
- Scheduling of refills and coordination of services with home care Providers, Case Managers, and Physicians or Other Healthcare Professionals.

If you are currently taking a Specialty Care Pharmacy Prescription Drug covered by the Plan and receive it through the OptumRx Specialty Pharmacy, you are already pre-enrolled in the Specialty Pharmacy Program. If you currently receive Specialty Care Pharmacy Prescription Drugs from a Participating Retail Pharmacy and would like to find out if you are eligible to enroll in the OptumRx Specialty Pharmacy Program, call OptumRx (Patient Care Coordinators) toll free Monday through

Friday: 9:00 a.m. to 8:00 p.m. EST; at **1-855-427-4682**. Additionally, a Clinician is always available 24 hours a day, 7 days a week for emergency on-call services at the same toll-free number.

Specialty Medications typically are dispensed from OptumRx in 30-day supplies.

DRUGS REQUIRING PRIOR AUTHORIZATION

Some medications are covered by the Plan only for specific medical conditions or for a specific quantity and duration. Prior authorizations are based on a clinical review of the available evidence about effectiveness of the drug in question by the OptumRx Pharmacy & Therapeutics Committee, which considers clinical evidence, not cost. An OptumRx Pharmacist, in cooperation with your Physician, determines coverage based on clinical guidelines and the manufacturer's specifications by reviewing the appropriateness of the medication, dosage and duration prescribed for certain conditions. Examples of some medications and uses that may require review (i.e., "prior authorization") are explained below; however, this is not an exhaustive list. Prior authorization may be required for:

- Amevive
- Androgens and anabolic steroids
- Anticonvulsant agents (e.g., Topamax and Zonegran)
- Anti-diabetic Agents (e.g., Byetta)
- Anti-emetics
- Antifungal agents
- Anti-influenza agents
- Anti-narcoleptic agents (e.g., Provigil)
- Antineoplastic agents (e.g., Gleevec)
- Antineoplastic agents (e.g., Iressa)
- Antiplatelet agents
- Appetite and weight-loss therapy
- Central nervous system stimulants (e.g., Strattera)/amphetamines
- COX 2 inhibitors
- Dermatologicals (e.g., Accutane, Amevive, Panretin gel, Penlac Solution, Raptiva, Regranex gel, Retin-A and co-brands—all dosage forms)
- Drugs to treat impotency
- Enbrel
- Erythroid stimulants
- Fertility agents
- Gaucher Disease therapy (i.e., Zavesca)
- Gleevec (e.g., Temodar, Avastin, Dacogen/Vidaza, Erbitux, Nexavar, Sprycel, Sutent, Vectibox)
- Growth Hormone Receptor Antagonist
- Human growth hormones
- Hypnotic agents
- Immunomodular therapy (e.g., Thalidomide, Revlimid)
- Immune Globulins (IVIG)
- Inhaled beta antagonist (i.e., Xopenex)
- Interferons (e.g., Alpha, Beta, Gamma, Pegasys)

- Migraine therapy agents (e.g., Imitrex, Zomig, Maxalt)
- Multiple Sclerosis therapy
- Myeloid stimulants
- Pain therapy (e.g., Stadol, Toradol)
- Pain therapy-narcotic (i.e., Actiq, Fentora)
- PPI (protein pump inhibiter) ulcer agents
- Rheumatologicals (e.g., Arava, Enbrel, Humira, Kineret, Remicade)
- Ribavirin therapy
- Vfend
- Respiratory Syncytial Virus (RSV) agents
- Xolair
- Zyvox
- Formulary Step Edits (Depression, Intranasal Steroids, Osteoporosis, Hypnotics, PPIs)

If you submit a prescription for a drug at a Retail Pharmacy that requires review or prior authorization, the retail Pharmacist will tell you that approval is needed before the prescription can be filled. The Pharmacist will give you or your Physician a toll-free number to call. If you use OptumRx Home Delivery, OptumRx will contact your Physician directly. When a coverage limit is triggered, more information is needed to determine whether your use of the Prescription Drug meets the Plan's coverage conditions. OptumRx will notify you and your Physician of the decision in writing. *If coverage is approved,* the letter will indicate the amount of time for which coverage is valid. *If coverage is denied,* an explanation will be provided, along with instructions on how to submit an appeal.

Prior authorization may include step therapy (requiring trial and failure of one or more first-line medications before a medication is covered), quantity limits, or restriction of coverage to certain populations or conditions, as the evidence suggests effectiveness.

If you have any questions regarding coverage of a specific drug, please check the OptumRx website (through the HealthFlex/WebMD website at **wespath.org**) or call the OptumRx member services department at **1-855-239-8471.**

You may also send your communications to the following addresses:

OptumRx
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799

OptumRx
Prior Authorization Department
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799

SHOULD I USE OPTUMRX HOME DELIVERY OR A RETAIL PHARMACY?

When you need a Prescription Drug for a limited time, use a Participating Retail Pharmacy to maximize your benefits. If you need a Prescription Drug for an extended time (sometimes called a maintenance drug), you can best utilize your HealthFlex benefits by using OptumRx Home Delivery or a 90-day maintenance supply from a Walgreens Retail Pharmacy.

USING A RETAIL PHARMACY

Under the Plan, you are allowed *a total of three fills* of a maintenance medication at a Retail Pharmacy (one original fill plus two refills). *Additional fills will not be covered by the Plan; you will pay for such fills at the full price if you use a Retail Pharmacy, even if it is a Participating Retail Pharmacy.* Each prescription fill can be for no more than a 30-day supply. **Important:** You are allowed a total of *three* fills for a specific medication, even if each fill is for less than 30 days.

The amount you pay for Prescription Drugs depends on whether you use an OptumRx Participating Retail Pharmacy or an Out-of-Network Pharmacy. At a Participating Retail Pharmacy, there are no Claim Forms to file; you simply pay your portion (i.e., your Co-payment) at the Participating Retail Pharmacy. Your portion will be based on the negotiated (discounted) price of the medication, which might include fees that are separately broken out and charged as part of the discounted cost of the medication. Please refer to *The Schedule of Prescription Drug Benefits* at the end of this Booklet for details about Co-payments. If you have a WageWorks Healthcare Card (also called the "HealthFlex debit card") for a health reimbursement account (HRA, health savings account (HSA) and/or health care flexible spending account (FSA), you may use your card to pay the retailer—as long as there is sufficient money in your account to cover your cost of the prescription. Participating Retail Pharmacies extend beyond Walgreens Pharmacies for the 30-day Retail benefit for short-term drugs.

At a Non-Participating Retail Pharmacy, you must pay in full for your prescription and submit a Claim for reimbursement to OptumRx. If the Non-Participating Retail Pharmacy charges you more than the Allowable Amount (based on pricing at a Participating Retail Pharmacy), you will be reimbursed an amount equal to the Allowable Amount minus the Co-payment. You should mail your Claim for reimbursement to the address provided on the OptumRx form.

Any reimbursement will be sent directly to you and made according to the Plan's Prescription Drug benefit provisions, as outlined on *The Schedule of Prescription Drug Benefits*. If any request for reimbursement is denied or reduced other than for Co-payments, please refer to the appeal provisions in the *Prescription Drug Appeals* section of this Benefit Booklet.

MAINTENANCE MEDICATIONS

OptumRx Home Delivery Program (i.e., an OptumRx company that is your mail-order program) or a Walgreens Retail Pharmacy should be used for maintenance (long-term) medications. You can receive up to a 90-day supply of medication for one Co-payment through the Home Delivery or at a Walgreens Pharmacy. Prescriptions must be filled as prescribed by your Physician (refills cannot be combined to equal a 90-day supply)—meaning your Physician must prescribe a 90-day supply of the drug(s). Please refer to *The Schedule of Prescription Drug Benefits* for details about Co-payments for pharmacy home-delivery or 90-day supplies from Walgreens. *If you submit a prescription for less than a standard 90-day supply of a Prescription Drug to OptumRx and*

OptumRx is able, in its reasonable judgment, to dispense such supply, you will be charged a Co-payment for a full 90-day supply of the Prescription Drug.

Retail Refill Allowance (RRA) Program
The Plan maintains a Retail Refill Allowance Program policy. This Program requires that you use OptumRx Home Delivery or a Walgreens Retail Pharmacy for a 90-day supply) if you are prescribed a maintenance medication (long-term Prescription Drug), rather than refilling multiple 30-day prescriptions for the same Prescription Drug at a Retail Pharmacy. If you or a covered Dependent receives a prescription for a maintenance medication and you do not use OptumRx Home Delivery or a Walgreens Retail Pharmacy for a 90-day supply, your Prescription Drugs may not be covered*. Participants will be allowed to obtain three 30-day fills (the initial fill plus two refills) of maintenance Prescription Drugs at a Participating Retail Pharmacy. For all subsequent fills, Participants must use OptumRx Home Delivery* or a Walgreens Retail Pharmacy for a 90-day supply *for the maintenance Prescription Drug to be covered. Otherwise, the Participant will be responsible for paying 100% of the discounted cost of the Prescription Drug.*

In certain circumstances, you may not be required to use OptumRx Home Delivery or a Walgreens Retail Pharmacy for a 90-day supply. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local Participating Retail Pharmacy (and are therefore exempt from the mandatory home-delivery program provision outlined above). These would be filled in 30-day supplies at a Participating Retail Pharmacy.

For example, if you have a prescription for any of the following medications, the Plan may allow you to receive multiple refills at your local Participating Retail Pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). **Please note:** Drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). **Please note:** Long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them because refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is treating cancer.
- Compounded medications that are filled at an OptumRx accredited compounding pharmacy.
- Medications that are considered to be hazardous material.

Filling Prescriptions through the Optum Rx mail-order program (an OptumRx company):

For your first time ordering a prescription from OptumRx Home Delivery, you can either have your physician provide the prescription directly to OptumRx through e-prescription, fax or phone; you may also mail in the original paper prescription. To order medications from OptumRx Home Delivery, please contact member services to request a new prescription. An agent will work with your provider's office to obtain a new prescription on your behalf. For security reasons, you must be a registered member of the OptumRx website or enter a secure WebMD username and password. You will need to confirm your information and provide the contact information for your Physician. If you prefer, you can have your Physician call **1-855-239-8471** for instructions on how to fax your prescription to OptumRx. For your first prescription, you will receive your medication in approximately 7 to 10 days if no additional authorization is needed. If you have a written prescription to mail, you will need to complete an order form (available from the OptumRx website or by calling the OptumRx member services department at **1-855-239-8471**) to include with your prescription. The prescription and order form should be mailed to the address provided on the form.

Once you have initiated your prescription delivery through OptumRx Home Delivery, you can request refills online or by phone via the member services department.

Please note: You can access the OptumRx website through the HealthFlex/WebMD website. Go to **wespath.org** and click on "**HealthFlex/WebMD**." Enter your WebMD username and password. Then choose "OptumRx" under the Benefits drop-down menu or in the HealthFlex Vendor Links column. Single sign-on capability means you won't need to enter another username/password to refill prescriptions or check the status of your claim.

Coordination with Other Prescription Drug Coverage

If you or your Dependents have Prescription Drug coverage through HealthFlex and through another group health plan or other insurance, OptumRx *will not* coordinate its payment for Prescription Drugs or Prescription Drug related expenses with those of the other group health plan or insurance. Therefore, at the time you place an order (make a claim) for Prescription Drugs (whether through a retail pharmacy or the Catamaran Home Delivery service) and you use the HealthFlex benefit (i.e., by presenting your HealthFlex ID Card or entering your HealthFlex ID Card number), OptumRx will pay for the Prescription Drug Claim as the Primary Plan. If you submit a claim for Prescription Drugs or related expenses paid by other group health plan or insurance, OptumRx *will not pay any further benefits* for such Prescription Drug Claim costs.

Drug Utilization Review (DUR)

For your safety, when you have your prescription filled, the Pharmacist and OptumRx may access information about your previous prescriptions electronically and check Pharmacy records for Prescription Drugs that conflict or interact with the medicine then being dispensed. If there is a question, the Pharmacist will work with you and your Physician before dispensing the medication. This is an automatic feature available only with prescriptions purchased through a Participating Retail Pharmacy and the OptumRx Home Delivery service

Special Prescription Program Services Emergency Pharmacist Consultation

Access to Pharmacists is available 24 hours a day, 7 days a week, for emergency consultation.

Pharmacy Locator
A voice-activated system for locating Participating Retail Pharmacies within specific ZIP codes; call the member services department at **1-855-239-8471**.

This information is also available via the website, which can be accessed through the HealthFlex/WebMD website **(wespath.org)** or directly at **Optumrx.com.**

Telecommunications for Hearing-Impaired Participants
Call **1-866-261-0791** for TTY assistance.

Printed Materials for Visually Impaired Participants
Large-print or Braille labels are available upon request for prescriptions purchased through OptumRx Home Delivery. Call **1-855-239-8471** for information.

Prescription Drug Appeals
If your Claim for Prescription Drug Benefits has been denied in whole or in part, you may have your Claim reviewed. OptumRx will review its decision in accordance with the following procedure. Within 180 days after you receive notice of a denial or partial denial, write to OptumRx. OptumRx will need to know the reasons why you do not agree with the denial or partial denial.

Send your request to:

OptumRx
Prior Authorization Department
C/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799

You may also designate a representative to act for you in the appeal. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. OptumRx will generally give you a written decision within 60 days after it receives your request for review.

In accordance with the Patient Protection and Affordable Care Act (PPACA), because the Plan is not a "grandfathered plan," you have additional rights to appeal claims. OptumRx will follow the terms of the PPACA and the regulations issued by the Department of Health and Human Services implementing the PPACA regarding Claims for Prescription Drug Benefits, appeals and external reviews.

If you have filed a Claim for Prescription Drug benefits and have asked OptumRx to review your Claim, if it was initially denied in whole or in part, and your Claim has been denied in whole or in

part, upon appeal, you may file suit in state or federal court—only upon exhaustion of these administrative remedies.

General Limitations for Medical, Behavioral Health, and Prescription Drug Benefits

No payment for medical and behavioral health benefits or Prescription Drug benefits will be made for expenses incurred for you or any of your Dependents:

- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- For Charges made by a Hospital owned or operated by or which provides care or performs Services for the United States Government: a) unless there is a legal obligation to pay such Charges whether or not there is coverage; or b) if such Charges are directly related to a military-service-connected Sickness or Injury.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For Charges that would not have been made if the person had no coverage.
- To the extent that Charges are more than the Maximum Allowance or Allowable Amount.
- For Charges for services that are not Medically Necessary as determined by the Claims Administrator.
- For or in connection with Custodial Services, education or training.
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For Charges made by a Physician for or in connection with Surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 (one-half) of the amount otherwise payable for all other surgical procedures.
- For Charges made by an assistant surgeon in excess of 20 percent (20%) of the surgeon's allowable charge; or for Charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent (20%). For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Co-insurance or Deductible amounts.
- For Charges made for or in connection with the purchase or replacement of contact lenses or eyeglasses except as specifically provided under *Covered Services*; however, the purchase of the first pair of contact lenses or eyeglasses that follows cataract surgery will be covered.
- For Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- For Charges for supplies, care, treatment or Surgery that are not considered Medically Necessary, as determined by the Claims Administrator.

- For Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails, unless Medically Necessary.
- For or in connection with speech therapy, if such therapy is: a) used to improve speech skills that have not fully developed, b) can be considered custodial or educational, or c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered.
- For Charges made by any Provider who is a member of your family or your Dependent's family.
- For Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by the Claims Administrator to be:
  - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal;
  - the subject of review or approval by an Institutional Review Board for the proposed use; or
  - not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- For expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the Charges are incurred while traveling on business or for pleasure.
- For nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and Services, training or educational therapy for learning disabilities, developmental delays, autism or cognitive impairment/delay.
- For medical treatment for a person age 65 or older, who is covered under this Plan as a working retiree, or their age 65 or older Dependent, when payment is denied by the Medicare plan because treatment was received from an Out-of-Network Provider;
- For medical treatment when payment is denied by a Primary Plan (including Medicare) (see: Coordination of Benefits) because treatment was received from a Provider that is not a network or In-Network Provider in the Primary Plan's network.
- For Charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan.
- For medical and Hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the Plan, only the first 30 days and delivery are covered.

Coordination of Benefits for Medical and Behavioral Health Claims

Coordination of Benefits (COB) applies when you have health care coverage through more than one group plan or program. The purpose of COB is to ensure that there is not a duplication of benefit payments. In other words, the total payment from this Plan as a secondary payer (as a Secondary Plan) will not, when added to the benefit paid by the primary plan (the Primary Plan), exceed what this Plan would have paid if it were the Primary Plan. It is your obligation to notify the Claims Administrator of the existence of such other group coverages.

Note: The coordination of benefits rules described in this section apply only to claims for medical and behavioral health benefits. The Program does not pay secondary benefits for Prescription Drug Claims. See the section entitled *Coordination with Other Prescription Drug Coverage*, above, for more information. For coordination of benefits rules related to dental benefits, please review the applicable benefit booklet or certificate of insurance. For coordination of benefits rules related to vision benefits, please contact Vision Service Plan (VSP) at the number listed in the *Vision Benefits* section of this Benefit Booklet.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

- The coverage under which the patient is the Eligible Person or Participant (rather than a Dependent) is the Primary Plan (meaning that full benefits are paid under that program). The other coverage is the Secondary Plan and pays only any remaining eligible Charges up to what the Secondary Plan would pay if it were the Primary Plan.

When a Dependent child receives services, the birthdays of the child's parents are used to determine which coverage is the Primary Plan if the Dependent child is covered under both parents' plans. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the Calendar Year will be considered the Primary Plan coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is the Primary Plan. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either the Primary Plan or the Secondary Plan, then the provisions of the other coverage will determine which coverage is the Primary Plan.

- However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan, contract or policy which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a plan, contract or policy which covers the child as a Dependent of the parent without custody;
- When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract or policy which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan, contract or policy which covers that child as a Dependent of the stepparent; and the benefits of a plan, contract or policy which covers that child as a Dependent of the stepparent will be determined before the benefits of a plan, contract or policy which covers that child as a Dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the

benefits of a plan, contract or policy which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan, contract or policy which covers the child as a Dependent child. It is the obligation of the person claiming benefits to notify the Claims Administrator of such a court decree and to provide a copy of the court decree upon the Claims Administrator's request.

If none of the above rules apply, then the coverage that has been in effect the longest is the Primary Plan.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically the Primary Plan.

The Claims Administrator has the right in administering these COB provisions to:

- Pay any other organization an amount that it determines to be warranted if payments that should have been made by the Claims Administrator have been made by such other organization under any other group program; and
- Recover any overpayment that the Claims Administrator may have made to you, any Provider, insurance company, person or other organization.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Medicare Secondary Payer rules of the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

RECOVERY OF EXCESS BENEFITS

If the Claims Administrator pays Charges for benefits that should have been paid by the Primary Plan, or if the Claims Administrator pays Charges in excess of those for which the Plan is obligated to provide under its terms, the Claims Administrator will have the right to recover the actual payment made or the reasonable cash value of any services.

The Claims Administrator will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organizations. If requested, you shall execute and deliver to the Claims Administrator such instruments and documents as it determines are necessary to secure the right of recovery.

RIGHT TO RECEIVE AND RELEASE INFORMATION

The Claims Administrator, with or without consent or notice to you, may obtain information from and release information to any other health care plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide any information the Claims Administrator requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted Claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits paid under the Primary Plan) is required before the Claim will

be processed for payment. If no response is received within 90 days of the request, the Claim will be denied. If the requested information is subsequently received, the Claim will be processed.

MEDICARE ELIGIBLES

The Claims Administrator will pay on behalf of the Plan as the Secondary Plan only as permitted by the Medicare Secondary Payer rules of the Social Security Act of 1965, as amended, for the following:

- A former Employee or Participant who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan.
- A former Employee's or Participant's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan.
- An Employee or Participant eligible for Medicare due to disability.
- The Dependent of an Employee or Participant whose employer and each other employer participating in the Plan have fewer than 100 employees and that Dependent is eligible for Medicare due to disability.
- An Employee or Participant or a Dependent of an Employee or Participant of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age.
- An Employee or Participant, retired Employee or Participant, Employee's or Participant's Dependent or retired Employee's or Participant's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

The Claims Administrator will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he or she would receive if he or she had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he or she would receive if he or she were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a Provider, to be the amount he or she would receive in the absence of such a private contract.

Your Medicare Secondary Payer Responsibilities

If you are Medicare-Eligible: In order to assist your Plan Sponsor and Wespath in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator, your Plan Sponsor and Wespath regarding the Medicare eligibility of you, your Spouse and Enrolled Dependents. In addition, if you, your Spouse or Enrolled Dependent becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Plan Sponsor or the Plan Administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

If you are eligible for, but not enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare In-Network Provider.

When calculating the Plan's Benefits in these situations, for administrative convenience the Claims Administrator in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Expenses for Which a Third Party May be Liable

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness. If you incur an expense for a Covered Service for which, in the reasonable opinion of the Claims Administrator, another party may be liable:

- The Claims Administrator shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Plan. You or your representative shall execute such documents as may be required to secure the Claims Administrator's subrogation rights.
- Alternatively, the Claims Administrator may, at its sole discretion, pay the benefits otherwise payable under the Plan. However, you must first agree in writing to refund to the Claims Administrator the lesser of: a) the amount actually paid for such Covered Services by the Claims Administrator; or b) the amount you actually receive from the third party for such Covered Services at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award, or otherwise.

Limitations of Actions

You cannot bring any legal action against the Plan, Wespath or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in *How to File a Medical Claim* and all required reviews of your claim have been completed (i.e., you have exhausted your administrative remedies). If you want to bring a legal action against the Plan, Wespath or the Claims Administrator, you must do so within 3 years from the expiration of the time period in which a request for reimbursement must have been submitted or you lose any rights to bring such an action against the Plan, Wespath or the Claims Administrator.

You cannot bring any legal action against the Plan, Wespath or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this Benefit Booklet. After completing that appeal process, if you want to bring a legal action against the Plan, Wespath or the Claims Administrator, you must do so within 3 years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against the Plan, Wespath or the Claims Administrator.

Information and Records

It is your personal responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, or any other

person or entity, having knowledge of records relating to: a) any Sickness or Injury for which a Claim or Claims for benefits are made under the Plan; or b) any medical history that may be pertinent to such Claim or Claims, furnish to the Claims Administrator or its agent, and agree that any such Provider, person or entity may furnish to the Claims Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such Sickness, Injury, Claim or Claims. In addition, the Claims Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claims Administrator, your Plan Sponsor and Wespath information regarding you or your Dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claims Administrator will be able to make Claim Payments in accordance with Medicare Secondary Payer laws.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- Under this Plan, the Claims Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claims Administrator may pay benefits to you if you receive Covered Services from an Out-of-Network Provider. The Claims Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- Once Covered Services are rendered by a Provider, you have no right to request the Claims Administrator not to pay the Claims submitted by such Provider and no such request will be given effect, except in situations where a Covered Person's request for nonpayment is because Services have not been rendered as described in the Claim. In addition, the Claims Administrator will have no liability to you or any other person because of its rejection of such request.
- A Covered Person's Claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Participant. Coverage under this Health Care Plan is expressly non-assignable and non-transferable, and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for benefits or coverage shall be null and void.

YOUR PROVIDER RELATIONSHIPS

- The choice of a Provider is solely your choice, and the Claims Administrator will not interfere with your relationship with any Provider.
- Neither the Plan, Wespath, nor the Claims Administrator undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claims Administrator, Plan and Wespath are not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services that can only be legally performed by a Provider are not provided by the Claims Administrator, the Plan or Wespath. Any contractual relationship between a Physician and an Administrator Provider

shall not be construed to mean that the Claims Administrator is providing professional service.

- The use of an adjective such as Participating, Administrator or approved in modifying (i.e., describing) a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- Each Provider provides Covered Services only to you and does not deal with or provide any Services to your employer or Plan Sponsor (other than as an individual Participant) or Wespath's Health Benefit Program.

In-Network Providers have signed an Agreement with the Claims Administrator to accept the Maximum Allowance as payment in full. Such In-Network Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claims Administrator's benefit payment and the Maximum Allowance for the particular Covered Service—that is, your program Deductible, Co-payment and Co-insurance amounts.

Out-of-Network Providers have not signed an agreement with the Claims Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claims Administrator's benefit payment and such Provider's charge to you.

RECOVERY OF OVERPAYMENT

If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Claims Administrator or Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, and/or
- All or some of the payment made by the Plan exceeded the benefits provided under the Plan.

The refund due will equal the amount paid by the Plan in excess of the amount the Plan should have paid under its terms. If the refund is due from another person or organization, the Covered Person agrees to help the Claims Administrator and the Plan obtain the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Claims Administrator 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 Claims Administrator and the Plan may have other rights in addition to the right to reduce future Benefits.

REBATES AND OTHER PAYMENTS

The Plan and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. The Plan and the Claims

Administrator do not pass these rebates on to you, nor are they taken into account in determining your Co-payments.

ADMINISTRATIVE SERVICES

The Plan and Claims Administrator may, in their sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as Claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in the sole discretion of the Plan and Claims Administrator. The Plan and Claims Administrator are not required to give you prior notice of any such change, nor obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Your Other HealthFlex Benefits

DENTAL BENEFITS

Dental benefits are available under the Plan to eligible Participants whose Plan Sponsors have elected to provide dental benefits through an Adoption Agreement. Please contact your Plan Sponsor with questions regarding the availability of dental benefits for you. You may also contact Wespath regarding eligibility and other dental benefits questions. Connecticut General Life Insurance Company (CIGNA) is the Claims Administrator for dental benefits under the Plan. CIGNA administers utilization, review, benefit payment and case management of your dental benefits. Claims for dental benefits should be submitted to CIGNA, not to the Claims Administrators for medical or Prescription Drug benefits.

A detailed description of your dental benefits can be found in the HealthFlex Dental Benefits Booklet, available online after logging into the HealthFlex/WebMD website at **wespath.org**.

CIGNA customer service coordinators are available at **1-800-CIGNA-24** (**1-800-244-6224**) to answer questions about your dental benefits Monday through Friday (except holidays) from 9:00 a.m. to 5:00 p.m., Eastern time. If you are calling due to a dental emergency, follow the directions as instructed on the CIGNA voice response system. You can also find information about your dental benefits online at **cigna.com**.

VISION BENEFITS

The Plan provides your vision benefits through Vision Service Plan Insurance Company (VSP). VSP is the Claims Administrator for vision benefits under the Plan. Any Claim for vision benefits should be submitted to VSP, not the Claims Administrators for medical or Prescription Drug benefits. For more complete information regarding your vision coverage, you should consult the materials provided by VSP.

To find out more about your vision benefits under the Plan or to find an In-Network Provider of vision benefit services you may call VSP at **1-800-977-7195** or visit **vsp.com**. You also can find information after logging in to HealthFlex/WebMD at **wespath.org**.

Benefit Options
Depending on the choices your Plan Sponsor has elected on its Adoption Agreement, you may or may not be eligible for the vision materials benefits. Please contact your Plan Sponsor if you have questions regarding the availability of vision materials benefits to you. Your Plan Sponsor may choose different levels of coverage for vision benefits for its Participants. Plan Sponsors may choose to provide Participants with: 1) a Full Coverage Option, 2) an Exam Core Option; or 3) a choice between the two options. Please contact your Plan Sponsor if you have questions about which option you may be covered under, if any.

Covered Vision Benefits
When all of the provisions of this Plan are satisfied, the Plan will provide benefits as outlined below for the services and supplies listed in this section. This list is intended to give you a general description of expenses for services and supplies covered by the Plan. You may also consult the benefit summary of vision benefits available online at the HealthFlex/WebMD website.

Benefits at a Participating VSP Provider
Exam Core Option

- Vision examinations by a Physician or Provider, limited to 1 every 12 months paid in full after a $20 Co-payment. Benefits include: case history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; tonometry (glaucoma test) in connection with a vision examination; and analysis of findings with recommendations and prescription if required. *You will be required to pay a $20 Co-payment.* Your benefit will be limited to a $45 reimbursement if you have your vision exam performed by a Provider that is not a VSP In-Network Provider.
- In addition to the benefits described above, through your relationship with VSP under the Plan, certain extra discounts on vision services and materials are available to you. These are not benefits paid by the Plan, but rather they are savings available to you on Out-of-Pocket expenses for vision services. Such Out-of-Pocket expenses may be eligible for reimbursement through a flexible spending account for health care expenses.

Full-Service Option

- Vision examinations by a Physician or Provider, limited to 1 every 12 months paid in full. *You will be required to pay a $20 Co-payment.* Your benefit will be limited to a $45 reimbursement if you have your vision exam performed by a Provider that is not a VSP In-Network Provider.
- Glass or plastic lenses prescribed by a Physician or Provider, limited to one pair every 12 months. Benefits include: single vision, lined bifocal and lined trifocal lenses. *You will be required to pay a $20 Co-payment.* Your benefit will be limited to a reimbursement of: 1) up to $30 for single vision lenses, 2) up to $50 for bifocal lenses, 3) up to $65 for trifocal lenses if you purchase your glasses through a Provider that is not a VSP In-Network Provider.
- Frames to hold prescribed lenses, limited to one pair every 24 months. Benefits include frames of your choice up to $160 with a discount of 20% off of any Out-of-Pocket expenses

(e.g., frames cost beyond $160). Your benefit will be limited to a $70 reimbursement if you purchase your glasses through a Provider that is not a VSP In-Network Provider.

- Contact lenses benefits include: contact lenses and fitting evaluation exam up to $160 in place of lenses and frames, whether Medically Necessary or as an elective alternative to conventional lenses. *No Co-payment is required for contact lenses.* Your benefit will be limited to a $105 reimbursement if you purchase your contact lenses through a Provider that is not a VSP In-Network Provider.
- In addition to the benefits described above, through your relationship with VSP under the Plan, certain extra discounts on vision services and materials are available to you. These are not benefits paid by the Plan, but rather they are savings available to you on Out-of-Pocket expenses for vision services. Such Out-of-Pocket expenses may be eligible for reimbursement through a flexible spending account for health care expenses:
  - Laser vision correction discounts at VSP In-Network Providers.
  - Average savings of 20-25% on lens enhancements such as scratch resistant and anti-reflective coatings and progressives.
  - 20% discount toward the purchase of additional prescription glasses and sunglasses at VSP In-Network Providers.
  - Exclusive pricing on annual supplies of popular brands of contact lenses.
  - 15% discount on the cost of contact lens exams (fitting and evaluation).

Premier Option

- Vision examinations by a Physician or Provider, limited to one every 12 months paid in full. *You will be required to pay a $20 Co-payment.* Your benefit will be limited to a $45 reimbursement if you have your vision exam performed by a Provider that is not a VSP In-Network Provider.
- Glass or plastic lenses prescribed by a Physician or Provider, limited to one pair every 12 months. Benefits include: single vision, lined bifocal and lined trifocal lenses. *You will be required to pay a $20 Co-payment.* Your benefit will be limited to a reimbursement of: 1) up to $30 for single vision lenses, 2) up to $50 for bifocal lenses, 3) up to $65 for trifocal lenses if you purchase your glasses through a Provider that is not a VSP In-Network Provider.
- Frames to hold prescribed lenses, limited to one pair every 12 months, in addition to any contact lens benefit. Benefits include frames of your choice up to $200 with a discount of 20% off any Out-of-Pocket expenses (e.g., frames cost beyond $150). Your benefit will be limited to a $70 reimbursement if you purchase your glasses through a Provider that is not a VSP In-Network Provider.
- Contact lenses benefits include: contact lenses and fitting evaluation exam up to $200, in addition to any lens and frame benefit, whether medically appropriate or as an elective alternative to conventional lenses. *No Co-payment is required for contact lenses.* Your benefit will be limited to a $105 reimbursement if you purchase your contact lenses through a Provider that is not a VSP In-Network Provider.
- Covered Lens Options
  - UV Protection is covered in full
  - Anti-Reflective Coatings are covered in full after a $25 copay

- In addition to the benefits described above, through your relationship with VSP under the Plan, certain extra discounts on vision services and materials are available to you. These are not benefits paid by the Plan, but rather they are savings available to you on Out-of-Pocket expenses for vision services. Such Out-of-Pocket expenses may be eligible for reimbursement through a flexible spending account for health care expenses.
  - Laser vision correction discounts at VSP In-Network Providers.
  - Average savings of 20-25% on lens enhancements such as scratch resistant and anti-reflective coatings and progressives.
  - 20% discount toward the purchase of additional prescription glasses and sunglasses at VSP In-Network Providers.
  - Exclusive pricing on annual supplies of popular brands of contact lenses.
  - 15% discount on the cost of contact lens exams (fitting and evaluation).

Co-payments and Out-of-Pocket expenses for vision benefits do not apply toward the satisfaction of your Deductible or Out-of-Pocket Maximum for medical benefits. Co-payments and Out-of-Pocket expenses for vision benefits may, however, be reimbursable through a flexible spending account for health care expenses.

Vision Expenses Limitations (Options Available at Additional Cost)
The VSP Plan is designed to provide your basic eyewear needs. It does not cover items that are considered cosmetic or elective. The following options will require an additional charge over the covered benefit. You must pay these additional charges directly to the Provider. The extra charges may be eligible for reimbursement through a flexible spending account.

Examples:
- Blended (no-line) bifocal.
- Progressive power multifocal lenses.
- Polished bevels and faceted lenses.
- Scratch coating, UV coating (fully covered in Premier plan), anti-reflective coating.
- Slab-off lenses.
  - Polycarbonate, polaroid, photochromic lenses.
  - Oversized lenses (larger than 62 mm).
  - Prism lenses.
  - Cosmetic lenses.
  - Tints on lenses.

Vision Expenses Not Covered
No benefits are available for the following products and services:

- Replacement frames and lenses except at normal intervals when services are otherwise available.
- Non-prescription sunglasses.
- Orthoptics, vision training or any associated supplemental testing.
- Frame cases.
- Low (subnormal) vision aids.

- Eye exams required by an employer as a condition of employment.
- Services and materials provided by another vision plan.
- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation.
- Benefits provided under any Participant's medical coverage.
- Medical or surgical treatment of the eyes.
- Circumstances described in the section of this Benefit Booklet entitled *General Limitations for Medical and Prescription Drug Benefits*.

Other Important Provisions

NO WAIVER

The failure of Wespath or the Claims Administrator to enforce strictly any term or provision of this Benefit Booklet or the Plan will not be construed as a waiver of such term or provision. Wespath reserves the right to enforce strictly any term or provision of this Benefit Booklet and the Plan at any time.

PROVIDER NON-DISCRIMINATION

The Plan shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law.

PHYSICIAN/PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician/patient relationship. Physicians and Other Health Care Providers are not agents or delegates of any employer, Plan Sponsor, Wespath or the Claims Administrator. Nothing contained in this Benefit Booklet or the Plan will require you or your Dependent to commence or continue medical treatment by a particular Provider. Furthermore, nothing in this Benefit Booklet or the Plan will limit or otherwise restrict a Physician's judgment with respect to the Physician's ultimate responsibility for patient care in the provision of medical services to you or your Dependent.

THE PLAN IS NOT A CONTRACT OF EMPLOYMENT

Nothing contained in this Benefit Booklet or the Plan will be construed as a contract or condition of employment between any employer and any Employee. All Employees are subject to discharge to the same extent as if this Benefit Booklet and the Plan had never been adopted.

RIGHT TO AMEND OR TERMINATE PLAN

Wespath reserves the right to amend, modify or terminate the Plan in any manner, for any reason, at any time, and without prior notification.

YOUR RIGHTS

If you have any questions about your rights under HIPAA or the PPACA, you should contact the appropriate department of the U.S. Department of Health and Human Services. *For primarily HIPAA concerns,* contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200

Independence Ave. SW, Room 509F, HHS Building, Washington, D.C. 20201. *For PPACA concerns,* contact the Center for Consumer Information and Oversight, U.S. Department of Health and Human Services, 200 Independence Ave. SW, Washington, D.C. 20201.

PLAN'S STATUS AS A CHURCH PLAN

Use of the terms Co-insurance, Co-payment, Deductible and premium in this Benefit Booklet do not imply that either Blue Cross and Blue Shield of Illinois or OptumRx insure the Plan. Similarly, use of such terms does not imply that the Plan or Wespath are in the "business of insurance." The Plan is offered by Wespath as a self-funded Church Plan only for the benefit of eligible clergy and Employees, and their families, of organizations affiliated with Wespath through The United Methodist Church. Blue Cross and Blue Shield of Illinois and OptumRx are merely third-party administrators in a contractual relationship with the Plan and Wespath who are not financially responsible for any benefits paid under the Plan.

Though Church Plans are considered employee welfare benefit plans under Section 3(1) of ERISA, as indicated by Section 4(b)(2) of ERISA, Title I of ERISA does not apply to Church Plans. Therefore, most regulations issued by the U.S. Department of Labor do not govern the administration of the Plan. In addition, Church Plans are exempt from most state laws regulating insurers, such as state insurance licensing, solvency and funding requirements, by the Church Plan Parity and Entanglement Protection Act of 2000 (Parity Act). Self-insured Church Plans are also not subject to many other state laws and regulations that govern insurers because the Parity Act, along with certain state laws with respect to Church Plans, may remove such Plans from state insurance regulations.

CLERICAL ERROR

If a clerical error or other mistake occurs, that error does not create a right to benefits under the Plan. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlements. Oral statements made by the Plan Administrator, the Claims Administrator or any other person shall not serve to amend the Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by the Plan Administrator or its designees, including the Claims Administrator, in accordance with the terms of this Benefit Booklet and other Plan documents.

Termination of Coverage and Continuation Coverage

You will no longer be entitled to the health care benefits described in this Benefit Booklet if either of the events stated below should occur:

- If you no longer meet the previously stated description of an Eligible Person, or
- If the Plan of Wespath terminates.

Further, termination of the Administrative Services Agreement (Agreement) between the Claims Administrator and Wespath automatically terminates your coverage as described in this Benefit Booklet. It is the responsibility of Wespath to notify you in the event the Agreement is terminated with the Claims Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of Wespath's Agreement with the Claims Administrator.

No benefits are available to you for Services or supplies rendered after the date of termination of your coverage under the Plan described in this Benefit Booklet except as otherwise specifically stated in the *Continuation Coverage* provisions of the ***HealthFlex Summary Plan Description***. However, termination of Wespath's Agreement with the Claims Administrator and termination of your coverage under the Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Benefit Booklet, if one of your Dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (e.g., date of marriage, date of divorce, date the limiting age is reached).

Please refer to the ***HealthFlex Summary Plan Description*** for additional information regarding termination of coverage and Continuation Coverage.

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Your Plan Sponsor, Conference or Wespath, upon request, will give you detailed information about the Family and Medical Leave Act of 1993. You may also refer to the ***HealthFlex Summary Plan Description*** for information.

BENEFITS EXTENSION

Medical Benefits Extension During Hospital Confinement—If the coverage under this Plan ceases for you or your Dependent, and you or your Dependent are confined in a Hospital on that date, benefits will be paid for expenses incurred for Covered Services in connection with that Hospital confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date you are covered for medical benefits under another group health plan or policy;
- the date you or your Dependent are no longer confined in a Hospital; or
- 3 months from the date your coverage ceases.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy that exists when your coverage ceases or your Dependent's coverage ceases.

Definitions

ACTIVE SERVICE
You will be considered in Active Service:

- on any of your employer's or Conference's scheduled work days if you are performing the regular duties of your work on a permanent basis, and you are regularly scheduled to work 30 hours per week or more, on that day either at your employer's or Conference's place of business or at some location to which you are required to travel for your employer's or Conference's business;
- on a day which is not one of your employer's or Conference's scheduled work days, if you were in Active Service on the preceding scheduled work day.

ACUPUNCTURE
The term Acupuncture describes the traditional Chinese practice of puncturing the body with needles at specific points to cure disease or relieve pain.

AFFILIATED ORGANIZATION
The term Affiliated Organization means any of the organizations and corporations associated with Wespath through The United Methodist Church, as described in Section 414(e) of the Code and which is a participating organization in the Plan.

ALLOWABLE AMOUNT
The term Allowable Amount means the amount that the Plan will pay for Prescription Drugs based upon pricing at a Participating Retail Pharmacy.

ALTERNATE FACILITY
The term Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services
- Emergency health services
- Rehabilitative, laboratory, diagnostic or therapeutic services
- Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis

AMENDMENT
The term Amendment means any attached written description of additional Covered Services not described in this Benefit Booklet. Amendments are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Amendment.

AUTISM SPECTRUM DISORDERS
Autism Spectrum Disorders means a group of neurobiological disorders that includes Autistic Disorder, Rett Syndrome, Asperger's Syndrome, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDD NOS).

BED AND BOARD
The term Bed and Board includes all Charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

THE BOOK OF DISCIPLINE
The term *The Book of Discipline* means the body of church law established by the General Conference of The United Methodist Church, as amended from time to time.

BRAND NAME DRUG
The term Brand Name Drug means a single source or brand version of a multi-source brand drug set forth in First Databank's National Drug Data File or such other nationally recognized source, as reasonably determined by OptumRx.

CALENDAR YEAR
The term Calendar Year means a 12-month period beginning on January 1 and each 12-month period thereafter.

CHANGE IN STATUS EVENT
The term Change in Status Event refers to a change in coverage due to the following changes in status:

- Change in legal marital status due to marriage, death of a Spouse, divorce, annulment or legal separation.
- Change in number of Dependents due to birth, adoption, placement for adoption or death of a Dependent.
- Change in employment status of Participant, Spouse or Dependent due to termination or start of employment (Note: Appointment changes for clergy Employees are not considered Change in Status Events under the Plan).
- Changes in employment status of the Participant, Spouse or Dependent resulting in eligibility or ineligibility for coverage.
- Changes that cause a Dependent to become eligible or ineligible for coverage. Any changes in coverage must be consistent with the Change in Status Event.
- Significant changes in coverage such as the loss or change of a benefit option resulting from a move to a new ZIP code.

CHARGES
The term Charges means the actual billed Charges, except when the Provider has contracted directly or indirectly with the Claims Administrator for a different amount.

CHURCH PLAN
A Church Plan is an employee benefit plan established and maintained for its employees by a church or by a convention or association of churches, as established in Section 414(e) of the Code and Section 3(33) of ERISA.

CLAIM
The term Claim means notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service

received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge and any other information which the Claims Administrator may request in connection with Services rendered to you.

CLAIMS ADMINISTRATOR
For medical, behavioral health and hospitalization services provided under the terms of this Benefit Booklet and the Plan, the term Claims Administrator means Blue Cross and Blue Shield of Illinois. For administration of Prescription Drug benefits provided by the Plan under the terms of this Benefit Booklet, the Claims Administrator is OptumRx. For administration of mental and behavioral health benefits provided by the Plan under the terms of this Benefit Booklet, the Claims Administrator is United Behavioral Health.

CLAIM CHARGE
The term Claim Charge means the amount that appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

CLAIM PAYMENT
The term Claim Payment means the benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the benefits described in this Benefit Booklet. All Claim Payments will be calculated on the basis of the eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

CLINICIAN (FOR MENTAL/BEHAVIORAL HEALTH SERVICES)
For the purposes of mental/behavioral health services, the Term Clinician means any of the following behavioral health providers who is properly qualified by law and duly licensed or certified by the state in which he or she is located to provide Mental Health Services and Substance Use Disorder Services:

- Physician
- Psychologist
- Masters Level licensed Clinician

Please note: Any pastoral counselor who acts within the scope of his or her license, certification or practice act, as indicated, will be considered on the same basis as a Clinician.

Please note: Any Board Certified Behavior Analyst who acts within the scope of his or her license, certification or practice act, as indicated, will be considered on the same basis as a Clinician.
The fact that BCBS describes a provider as a Clinician does not mean that benefits for services from that provider are available to you under the Plan. See *Covered Behavioral Health Services* for more information.

For non-mental/behavioral health services, the definition of clinician is broader.

CODE
The term Code means the Internal Revenue Code of 1986, as amended.

CONFERENCE
The term Conference means an Annual Conference, Provisional Conference or Missionary Conference of The United Methodist Church that is located in a Jurisdictional Conference in the U.S. as such entities are defined in *The Book of Discipline*.

CO-INSURANCE
Co-insurance percentages represent the portion of Charges for Covered Services paid by you and the Plan after satisfaction of any applicable Deductible. These percentages apply only to Charges for Covered Services that do not exceed the Maximum Allowance. You are responsible for all non-covered expenses, including any amount that exceeds the Maximum Allowance for Covered Services.

Note: Use of the term "Co-insurance" in this Benefit Booklet does not imply that either Blue Cross and Blue Shield of Illinois or OptumRx insure the Plan. The Plan is offered by Wespath on a self-funded basis. Blue Cross Blue Shield of Illinois and OptumRx act as the third-party contract administrators and are not financially responsible for any benefits paid under the Plan. The Co-insurance amounts are shown on The Schedule of Benefits.

COORDINATED HOME CARE PROGRAM
The term 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. This program includes Skilled Nursing Service by a registered professional Nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

CO-PAYMENT
Co-payment, sometimes called a "co-pay," means the first-dollar amount you must pay for certain Covered Services under the Plan that is usually paid at the time the service is performed (e.g., Physician office visits or emergency room visits). Co-payments do not apply to your annual Deductible. Co-payments do apply to your annual Out-of-Pocket Maximum. The Co-payment amounts are shown on The Schedule of Benefits.

COSMETIC PROCEDURES
The term Cosmetic Procedures means procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

COST EFFECTIVE
The term Cost effective means the least expensive equipment or procedure that performs the necessary function or treatment.

COVERAGE DATE
The term Coverage Date means the date on which your coverage under the Plan begins.

COVERED BEHAVIORAL HEALTH SERVICE(S)
The term Covered Behavioral Health Service(s) means those Mental Health Services and Substance Use Disorder Services which are:

- Provided for the purpose of preventing, diagnosing or treating a Mental Illness, substance use disorder or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Clinician, facility or any other person.
- Described as a Covered Behavioral Health Service in this Plan under *Covered Behavioral Health Services*.
- Determined to be Medically Necessary.
- Pre-certified as required under the Plan or otherwise authorized as part of the plan's Utilization Review process.
- Not otherwise excluded as indicated under *Exclusions and Limitations*.
- In applying the above definition, ""scientific evidence" and "prevailing medical standards" shall have the following meanings:
- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

BCBS maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time) are available to Covered Persons and Clinicians by contacting BCBS.

COVERED PERSON
The term Covered Person means either the Primary Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person (also called a Participant).

COVERED PRESCRIPTION DRUG
The term Covered Prescription Drug means a drug that, under state or federal law, requires a prescription, including compound prescriptions, and for which benefits will be provided under the Plan.

COVERED SERVICE
The term Covered Service means a service and supply specified in this Benefit Booklet for which benefits will be provided.

CUSTODIAL CARE
The term Custodial Care means services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating);
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

CUSTODIAL SERVICES
The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DEDUCTIBLE
The term Deductible means the amount of Charges for Covered Services each Covered Person must pay during each year before the Plan will consider expenses for reimbursement, with the exception of certain services subject only to a co-payment. For non-HSA plans, the individual Deductible applies separately to each Covered Person. The family Deductible applies collectively to all Covered Persons in the same family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that Plan Year; however, the Participant may be responsible for an out-of-network Inpatient Hospital Deductible, certain specific benefit deductibles or costs beyond the Maximum Allowance. For qualified high-deductible health plans: if two or more individuals are covered, the full family deductible must be always be met before the plan pays (except preventive services).. Deductible amounts as shown on *The Schedule of Benefits*.

DEPENDENT
The term Dependent, for all Participants, regardless of a Participant's State of residence, means:

- your lawful Spouse; and
- any child of yours who is:
  - less than 26 years old; or
  - age 26 and older and:

- an unmarried child who is mainly dependent on you for financial support and is currently a covered dependent as a result of Michelle's Law;[1] or
- an unmarried child who is not self-supporting due to a physical or mental impairment.

A child includes one who is in the custody of the Participant, pursuant to an interim court order of adoption or placement for adoption, whichever comes first, whether or not a final order granting adoption is ultimately issued. It also includes a stepchild who lives with you. It also includes a child living with you for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached. If a Dependent is eligible after age 26 due to mental or physical impairment, benefits will continue as long as the child is not self-supporting, even if the Dependent is employed and eligible for group health insurance with that employer. If the Dependent elects other group health coverage and loses that coverage, the Dependent is eligible for coverage under HealthFlex if he or she still meets other criteria for coverage (e.g., not self-supporting).

No one may be considered as a Dependent of more than one Participant.

DIAGNOSTIC SERVICE

The term Diagnostic Service means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury. Such tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

ELIGIBLE EXPENSES

The term Eligible Expenses means expenses for Covered Services, incurred while the Plan is in effect, that are determined as stated below. Eligible Expenses are based on either of the following:

- When Covered Services are received from Network Providers, Eligible Expenses are the contracted fees with that Provider.
- When Covered Services are received from Non-Network Providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area; or (2) applying the negotiated rates agreed to by the Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors. When Covered Services are received from Non-Network Providers, unless you receive services as a result of an Emergency, you may be responsible for any remaining portion of the bill. This may be referred to as "balance billing" or billing the balance above the allowed Reasonable and Customary amount to the participant.

[1] Michelle's Law applies to full-time students enrolled at a post-secondary institution who are covered under their parent's health insurance plan and take a medical leave due to a serious injury or illness. Under the law, a "medical leave" means that the student is absent from school or reduces his or her full-time course-load to part-time.

- Eligible Expenses are determined at the Claims Administrator's discretion by either: (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area; or (2) applying the negotiated rates agreed to by the Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

ELIGIBLE PERSON
The term Eligible Person means an employee of Wespath, employee of an Affiliated Organization, or other Participant of the Plan maintained by Wespath who meets the eligibility requirements for this health coverage, in accordance with the terms of the Plan as described in the *Eligibility* section of this Benefit Booklet.

EMERGENCY
Emergency is a situation where anyone with average knowledge of health and medicine who experiences acute symptoms, including severe pain or a serious mental health or substance abuse disorder, condition or symptom would reasonably believe that failing to obtain immediate medical attention could seriously jeopardize his or her health. This standard includes seriously impaired bodily functions, serious dysfunction of any bodily organ or part, and serious jeopardy to the health of an unborn child.

EMERGENCY HEALTH SERVICES
Emergency Health Services means medical screening exams, including routinely available ancillary services, that a hospital emergency department is capable of performing to evaluate emergency medical conditions, as well as other exams and treatments available at and used by hospitals to stabilize patients with emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act).

EMPLOYEE
For purposes of this Benefit Booklet, the term Employee means a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church, or who is a common law employee of Wespath or an Affiliated Organization, including a former Employee who has retired.

ENROLLMENT PERIOD
The term Enrollment Period means the period specified by the Plan during which you may apply for coverage if you did not apply within 30 days of your Eligibility Date or Change in Status Event.

ENROLLED DEPENDENT
An Enrolled Dependent is a Dependent who is properly enrolled under the Plan.

ERISA
The term ERISA means the Employee Retirement Income Security Act of 1974, as amended.

EXCLUDED DRUG
The term excluded means, generally Non-Preferred Brand Name Drugs that are not on the OptumRx Formulary list and are not covered without clinical documentation of medical necessity.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES

Experimental or Investigational Services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within 1 year of the request for treatment) the Claims Administrator may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

FORMULARY

The term Formulary means the list of Generic Drugs and Brand Name Drugs that are preferred by the Plan. This list offers you choices, while helping you and the Plan keep the cost of Prescription Drugs down. HealthFlex uses the OptumRx Premium Formulary.

FREE-STANDING SURGICAL FACILITY

The term Free-Standing Surgical Facility means an institution that meets all of the following requirements:

- It has a medical staff of Physicians, Nurses and licensed anesthesiologists.
- It maintains at least two operating rooms and one recovery room.
- It maintains diagnostic laboratory and X-ray facilities.
- It has equipment for emergency care.
- It has a blood supply.
- It maintains medical records.
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis.
- It is licensed in accordance with the laws of the appropriate legally authorized agency.

GENERAL BOARD

The term General Board means the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois in its role as Plan Administrator. As of July 2016, the General Board is doing business as Wespath Benefits and Investments (Wespath).

GENERIC DRUG
Generic Drugs and their Brand Name Drug counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic Drugs may differ in color, size or shape from Brand Name Drugs, but the Food and Drug Administration requires that the active ingredients have the same strength, purity and quality as their Brand Name Drug counterparts. Generic Drugs may also be manufactured by either a single manufacturer or multiple manufacturers.

HEALTH REIMBURSEMENT ACCOUNT (HRA)
The term Health Reimbursement Accounts refers to health reimbursement arrangements as described in *IRS Notice 2002-45*. HRAs are employer (i.e., Plan Sponsor and Plan)-funded accounts that help Participants covered in the HRA Plan Benefit Options satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses. HRA Accounts do not include any Participant contributions.

HEALTH SAVINGS ACCOUNT (HSA)
Health Savings Accounts are employer-funded (i.e., funded by Plan Sponsor and Plan) and, if elected, participant-funded accounts for participants covered in an HSA Plan. Contributions into the HSA are limited to a maximum amount each year. HSAs help Participants covered in the HSA Plan Benefit Options to satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses.

HSA PLAN
HSA Plan refers to a Benefit Option under the Plan that is a qualified high-deductible health plan under the Code. The HSA Plan is designed to drive participants' behavior toward informed medical decision-making and typically carries higher deductible and out-of-pocket limits than the PPO Benefit Option under the Plan. The HSA Plan is generally accompanied by a health savings account (HSA) option, which may provide Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles in addition to the opportunity for participants to contribute to the HSA.

HIPAA
The term HIPAA means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by the Secretary of the Department of Health and Human Services. HIPAA provisions help protect the privacy of Personal Health Information (PHI).

HOME HEALTH AGENCY
The term Home Health Agency means a program or organization authorized by law to provide health care Services in the home.

HOSPICE CARE PROGRAM
The term Hospice Care Program means:

- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness; and
- A program for persons who have a Terminal Illness and for the families of those persons.

HOSPICE CARE PROGRAM PROVIDER
The term Hospice Care Program Provider means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE
The term Hospice Care Program Service means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPICE CARE SERVICES
The term Hospice Care Services means any services provided by:

- Hospital,
- Skilled Nursing Facility or a similar institution,
- Home Health Care Agency,
- Hospice Facility, or
- Any other licensed facility or agency under a Hospice Care Program.

HOSPICE FACILITY
The term Hospice Facility means an institution or part of it which:

- Primarily provides care for Terminally Ill patients,
- Is accredited by the National Hospice Organization,
- Meets standards established by the Claims Administrator, and
- Fulfills any licensing requirements of the state or locality in which it operates.

HOSPITAL
The term Hospital means:

- An institution licensed as a Hospital, which: a) maintains, on the premises, all facilities necessary for medical and surgical treatment; b) provides such treatment on an Inpatient basis, for compensation, under the supervision of Physicians; and c) provides 24-hour service by Registered Graduate Nurses.
- An institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a Provider of Services under Medicare, if such institution is accredited as a Hospital by The Joint Commission; or
- An institution which: a) specializes in treatment of Mental Health and Substance Abuse or other related illness; b) provides residential treatment programs; and c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL
A person will be considered Confined in a Hospital if he or she is a registered bed patient in a Hospital upon the recommendation of a Physician.

HRA PLAN
HRA Plan refers to a Benefit Option under the Plan that is designed to drive participants' behavior toward informed medical decision-making and typically carries higher deductible and out-of-pocket limits and fewer/no co-payments compared to the PPO Benefit Option under the Plan. The HRA plan is generally accompanied by a health reimbursement account, which provides Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles.

ID CARD
The term ID Card means the identification card that contains your Participant information issued to you by the Claims Administrator.

INITIAL ENROLLMENT PERIOD
The term Initial Enrollment Period means the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

INJURY
The term Injury means an accidental bodily injury.

IN-NETWORK PHARMACY (NETWORK PHARMACY)
The term In-Network Pharmacy means the OptumRx and Retail Pharmacies with which OptumRx has contracted, either directly or indirectly, to provide Prescription Drug Services. To find an In-Network Pharmacy, access the OptumRx Web page through the HealthFlex/WebMD website (**wespath.org**), log in and search under "Vendor Links") or at **OptumRx.com**.

IN-NETWORK PROVIDER (NETWORK PROVIDER)
The term In-Network Provider means a Hospital or Professional Provider that has entered into an agreement with the Claims Administrator or a Blue Cross and Blue Shield of Illinois Plan or Blue Cross Plan of another state to provide services at a predetermined cost under the agreement to participate in the PPO option of the Plan or a facility that has been designated by the Claims Administrator as an In-Network Provider.

The Providers qualifying as In-Network Providers may change from time to time. A list of the current In-Network Providers may be provided by the Claims Administrator.

INPATIENT
The term Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

INPATIENT REHABILITATION FACILITY
The term Inpatient Rehabilitation Facility means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, Occupational Therapy or speech therapy) on an inpatient basis, as authorized by law.

INPATIENT STAY
The term Inpatient Stay means an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

INTENSIVE BEHAVIORAL THERAPIES
The term Intensive Behavioral Therapies means educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA).*

INTENSIVE OUTPATIENT TREATMENT
The term Intensive Outpatient Treatment means a structured outpatient Mental Health Services or Substance Use Disorder Services treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

MAINTENANCE TREATMENT
The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current health status.

MANIPULATIVE THERAPY SERVICES
The term Manipulative Therapy Services means the conservative management of neuromusculo-skeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

MAXIMUM ALLOWANCE
The term Maximum Allowance means the amount determined by the Claims Administrator that In-Network Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Providers, whether Participating or Non-Participating, will be based on The Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claims Administrator.

MEDICAID
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

MEDICARE
The term Medicare means the federal program of medical care benefits for persons age 65 and older and for certain persons under age 65 who are disabled, provided under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE APPROVED OR MEDICARE PARTICIPATING
The term Medicare Approved or Medicare Participating means a Provider that has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER (MSP)
The term Medicare Secondary Payer means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their Spouses and, in some cases, Dependent children.

MEDICALLY NECESSARY/MEDICAL NECESSITY
The term Medically Necessary/Medical Necessity means health care services and supplies that are determined by the Claims Administrator to be:

- Required to meet your essential health needs;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
- Required for purposes other than the convenience of the Provider or the comfort and convenience of the patient; and
- Rendered in the least intensive setting that is appropriate for the delivery of health care.

MENTAL HEALTH SERVICES
The term Mental Health Services means Covered Behavioral Health Services for the diagnosis and treatment of Mental Illnesses that are 1) treated primarily with psychotherapy or other psychotherapeutic methods; and 2) listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Behavioral Health Service.

MENTAL ILLNESS
The term Mental Illness means those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

MULTI-SOURCE
The term Multi-source refers to a Brand Name Drug that has a Generic Drug equivalent. A Multi-source medication may be manufactured by either a single producer or multiple producers.

NAPRAPATH
The term Naprapath means a therapist who practices Naprapathy and who is duly licensed by a state licensing authority in states where such licensing is required.

NAPRAPATHY
The term Naprapathy means the treatment of disease by manipulation of joints, muscles and ligaments, based on the belief that many diseases are caused by displacement of connective tissues.

NAPRAPATHIC SERVICES
The term Naprapathic Services means the performance of naprapathic practice by a Naprapath that may legally be rendered by them.

NECESSARY SERVICES AND SUPPLIES
The term Necessary Services and Supplies includes:

- Any Charges, except Charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.
- Any Charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Any Charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any Charges for special nursing fees, dental fees or medical fees.

NURSE
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation R.N., L.P.N. or L.V.N.

OCCUPATIONAL THERAPIST
The term Occupational Therapist means a duly licensed Occupational Therapist.

OCCUPATIONAL THERAPY
The term Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPEN ENROLLMENT PERIOD
The term Open Enrollment Period means a period of time during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period. The Open Enrollment Period is sometimes called “Annual Election.”

OPTUMRX HOME DELIVERY
The term OptumRx Home Delivery means the program through the mail-order pharmacy in which Participants may submit a maintenance (long-term) prescription along with the applicable Co-payment for dispensing via the OptumRx home-delivery/mail-order service (i.e., ordered online, by phone or by mail and delivered to the participant through the U.S. Postal Service or commercial delivery courier).

OTHER HEALTH CARE FACILITY
The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and sub-acute facilities.

OTHER HEALTH CARE PROFESSIONAL
The term Other Health Care Professional means an individual, other than a Physician, who is licensed or otherwise authorized under the applicable state law to deliver medical Services and supplies. Other Health Care Professionals include, but are not limited to, physical therapists, registered Nurses and licensed practical Nurses.

OUT-OF-NETWORK PHARMACY (NETWORK PHARMACY)
The term Out-of-Network Pharmacy means a pharmacy other than an In-Network Pharmacy.

OUT-OF-NETWORK PROVIDER (NETWORK PROVIDER)
The term Out-of-Network Provider means a Provider other than an In-Network Provider.

OUT-OF-POCKET
The term Out-of-Pocket applies to expenses that call for Participants to spend cash (i.e., their own money), such as the Participant's share of Co-insurance, Co-payment or Deductible.

OUT-OF-POCKET MAXIMUM
The term Out-of-Pocket Maximum means the maximum amount of Charges for Covered Services you must pay during a Plan Year, including the Deductible, before the Co-insurance percentage of the Plan increases. The individual Out-of-Pocket Maximum applies separately to each Covered Person. When a Covered Person reaches the annual Out-of-Pocket Maximum, the Plan will pay 100% of additional Charges for Covered Services for that individual during the remainder of that Plan Year. The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. When the annual family Out-of-Pocket Maximum is reached, the Plan will pay 100% of Charges for Covered Services for any covered family member during the remainder of that Plan Year. However, expenses for services that do not apply to the Out-of-Pocket Maximum will never be paid at 100%.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any Charges for non-Covered Services.
- Co-payments for Covered Services available by an optional Amendment.
- Charges in excess of the Maximum Allowance
- Co-payments for Services available from HealthFlex vendors or administrators other than OptumRx and Blue Cross and Blue Shield of Illinois.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum that is determined by the medical Benefit Option in which you are enrolled (the one described in this Benefit Booklet). The annual Out-of-Pocket Maximum amounts are shown on *The Schedule of Medical Benefits.*

OUTPATIENT
The term Outpatient means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTICIPANT
The term Participant means either the Primary Participant or an Enrolled Dependent, but this term applies only while such person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Participant (also called a Covered Person).

PARTIAL HOSPITALIZATION/DAY TREATMENT
Partial Hospitalization/Day Treatment means a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

PHARMACY & THERAPEUTICS (P&T) COMMITTEE
A committee comprised of independent Medical Providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The OptumRx P&T Committee is responsible for objective evaluation, review, guidance and clinical recommendations for the safe therapeutic use of products contained within the formulary as well as clinical recommendations for prior authorizations. (The OptumRx formulary is a list of drugs and/or devices that may be listed on a formulary as preferred, non-preferred, and/or excluded with respect to plan benefits.)

PHYSICIAN
The term Physician means a licensed medical practitioner who is practicing within the scope of the license and who is licensed to prescribe and administer drugs and/or to perform Surgery.

PLAN
The term Plan means the Hospitalization and Medical Expense Program ("HealthFlex") maintained by Wespath on behalf of its Employees and the Employees and other Participants of the organizations and corporations affiliated with Wespath. The Plan is a Church Plan.

PLAN ADMINISTRATOR
The Plan Administrator of the Plan is the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, (Wespath) or its designee.

PRESCRIPTION DRUG
Prescription Drug means: (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

PREVENTIVE TREATMENT
The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

PRIMARY PARTICIPANT
The term Primary Participant means a full-time employee of Wespath, a full-time employee of an Affiliated Organization and any other person eligible under the terms of the Plan who is currently in Active Service and enrolled in the Plan (including retired Employees age 65 and over who are considered working-aged Employees under the MSP Rules and who do not work for an employer that has elected the small employer exception under the MSP Rules). The term also includes retired employees Wespath and Affiliated Organizations who are under the age of 65.

PRIVATE DUTY NURSING
The term Private Duty Nursing means Skilled Nursing services provided by an actively practicing licensed Nurse on a one-to-one basis. Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing of less than 8 hours per day. It does not include Custodial Care Service.

PLAN SPONSOR
The term Plan Sponsor means the Conference if the Primary Participant is an employee of a local church or a clergy member; or the Affiliated Organization for other Primary Participants.

PROVIDER
The term Provider means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you. Also see the definitions of In-Network Provider and Out-of-Network Provider.

PROFESSIONAL PROVIDER
The term Professional Provider means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claims Administrator or a Blue Cross and Blue Shield of Illinois Plan or Blue Cross Plan of another state.

PSYCHOLOGIST
Psychologist means a person who has a doctoral or other terminal degree in psychology from an organized, sequential program in a regionally accredited university or professional school and who is licensed and authorized by the state to practice as a professional psychologist.

RESIDENTIAL TREATMENT FACILITY
Residential Treatment Facility means a facility which provides a program of effective Mental Health Services and/or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Plan.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hours per day, structured milieu:

- Room and board
- Evaluation and diagnosis
- Counseling
- Referral and orientation to specialized community resources

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital for purposes of the Plan.

RETAIL PHARMACY
The term Retail Pharmacy means a pharmacy that is not OptumRx home-delivery pharmacy.

RETAIL REFILL ALLOWANCE (RRA) PROGRAM
The term Retail Refill Allowance Program is a requirement under the Plan pursuant to which Participants will only be allowed to obtain three fills (the initial fill, plus two refills) of maintenance (long-term) drugs at a Participating Retail Pharmacy. For all subsequent fills of the same drug at a Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost of the drug. **Please note:** 90-day supply fills of maintenance medications obtained from a Participation Walgreens Retail Pharmacy do not apply to this Retail limitation.

REVIEW ORGANIZATION
The term Review Organization refers to an affiliate of the Claims Administrator or another entity to which the Claims Administrator has delegated responsibility for performing Utilization Review Services. The Review Organization is an organization with a staff of Clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform Utilization Review Services.

SERIOUS MENTAL ILLNESS
Serious Mental Illness means a psychiatric illness as defined in the most current edition of the *Diagnostic and Statistical Manual (DSM)* published by the *American Psychiatric Association*. A Serious Mental Illness includes:

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (hypomanic, manic, depressive and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)
- Pervasive developmental disorders
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic, or with delayed onset)
- Anorexia nervosa and bulimia nervosa

SICKNESS
For the purposes of the Plan, the term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

SKILLED NURSING
The term Skilled Nursing means services provided by a Nurse that require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. It does not include Custodial Care Service.

SKILLED NURSING FACILITY
The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) that specializes in:

- Physical rehabilitation on an Inpatient basis.
- Skilled nursing and medical care on an inpatient basis, but only if that institution:
  - Maintains on the premises all facilities necessary for medical treatment;
  - Provides such treatment, for compensation, under the supervision of Physicians; and
  - Provides Nurses' Services.

SPINAL TREATMENT
Spinal Treatment means detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SPECIALIST
The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

SPOUSE
The term Spouse, for purposes of the Plan, means a person who is in a marital relationship with a Participant (or with a surviving Spouse) that exists in accordance with the law of the jurisdiction in which the Spouse resides, except that a person who is a "common-law" Spouse shall not be a Spouse for purposes of the Plan. A person who is a Spouse shall still be a Spouse even if the person is geographically or legally separated (but not yet divorced) from the person to whom he or she is married.

In certain circumstances, civil union partners and domestic partners of lay Employees may be covered, depending upon: (1) the law of the State in which the lay Employee resides and Plan Sponsor is located, (2) the elections of the Plan Sponsor. For more about this coverage see the section of the ***HealthFlex Summary Plan Description*** entitled "Domestic Partner Coverage."

SUBSTANCE USE DISORDER SERVICES
Substance Use Disorder Services mean Covered Behavioral Health Services for the diagnosis and treatment of alcoholism and substance use disorders, including a psychological and/or physiological

dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, that are: 1) treated primarily with psychotherapy or other psychotherapeutic methods; and 2) listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

Detoxification services given prior to and independent of a course of psychotherapy or substance use disorder treatment are not considered Substance Use Disorder Services.

The fact that a disorder is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Behavioral Health Service.

SURGERY
The term Surgery means the performance of any medically recognized, non-investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS
The term Temporomandibular Joint Dysfunction and Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TERMINAL ILLNESS
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of 6 months or less to live, as diagnosed by a Physician.

TIER 1 DRUG
The term Tier 1 Drug means, generally, Generic Drugs.

TIER 2 DRUG
The term Tier 2 Drug means, generally, Preferred Brand Name Drugs that are on the OptumRx Formulary list.

TIER 3 DRUG
The term Tier 3 Drug means, generally, Non-Preferred Brand Name Drugs that are not on the OptumRx Formulary list, as well as non-sedating antihistamines and lifestyle drugs such as Viagra.

UNPROVEN SERVICES
Unproven Services are services that are not consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within 1 year of the request for treatment) Wespath and the Claims Administrator may, in their discretion, determine that an Unproven Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, Wespath and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

URGENT CARE
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Claims Administrator, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the Participant should not travel due to any medical condition.

URGENT CARE CENTER
An Urgent Care Center is a facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UTILIZATION REVIEW
A Utilization Review is a pre-service, concurrent (ongoing) or post-service review and determination by UBH as to whether services and/or supplies are Covered Behavioral Health Services.

WESPATH
Wespath (Wespath Benefits and Investments) administers the HealthFlex plan and other health, welfare and retirement benefits and investments. Wespath is a general agency of The United Methodist Church.

General Information

Fiduciary and Administrative Duties

As the Plan Administrator, Wespath has an obligation to follow the terms of the Plan document. The Plan document names Wespath as both the administrator and fiduciary of the Plan. An administrator must perform its duties in a manner consistent with the terms of the Plan. A fiduciary must maintain and administer the Plan in the interest of the Plan and its participants. The fiduciary must perform its duties in a reasonable and prudent manner.

The Plan document grants Wespath the power to delegate fiduciary and non-fiduciary duties and obligations to agents and others.

Duties Assigned to the Plan's Claims Administrators

Under the terms of the administrative services agreements with the Claims Administrators, Wespath has delegated the administrative duties to Blue Cross and Blue Shield of Illinois (BCBSIL) and OptumRx to process claims and distribute benefits for the medical and Prescription Drug coverage under the Plan. Wespath, as the Plan Administrator, pays for those benefits through banking arrangements with the Claims Administrators. Wespath has also contractually delegated certain fiduciary duties to the Claims Administrators. Specifically, Wespath has delegated the fiduciary duties with respect to administering claims and hearing appeals of claim denials to BCBSIL and OptumRx. BCBSIL and OptumRx, as contracted fiduciaries, have the duty to administer benefits in accordance with the terms of the Plan and in the exclusive interest of the Plan and all of its participants. Wespath, despite the fact that it is still responsible for paying the benefits from Plan assets, does not have the authority, generally, to alter the decisions regarding the duties, i.e., claims and appeals processing, that have been assigned to the Claims Administrators.

For More Information

Here are some additional resources, should you have any questions after reviewing all of the information in this Benefit Booklet.

For more information about:

- **The HealthFlex Plan**
  Wespath Benefits and Investments
  1901 Chestnut Ave.
  Glenview, IL 60025
  wespath.org
  1-800-851-2201

- **Blue Cross and Blue Shield of Illinois**
  300 E. Randolph St.
  Chicago, IL 60601
  bcbsil.com
  1-866-804-0976

- **OptumRx**
  1600 McConnor Parkway
  Schaumburg, IL 60172
  OptumRx.com
  1-855-239-8471

The plans described in this document (collectively, the Plans) are maintained and administered by the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois [d.b.a. Wespath Benefits and Investments (Wespath)] The Plans are self-funded (or self-insured).

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should **not** be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of any conflict between this Benefit Booklet and the official plan documents (schedule of benefits, benefit grids, summary plan description, or plan document), the official plan documents will govern.

Wespath and its affiliates retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

The Plans are Church Plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States. The Plans do not cover all health care expenses, and Participants should read the official plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations, and policies. All benefits are subject to coordination of benefits provisions. The Plans are subrogated to all of the rights of a plan Participant against any party liable for such Participant's Sickness or Injury, to the extent of the reasonable value of the benefits provided to such Participant under the Plans. The Plans may assert this right independently of a plan Participant, and such Participant is obligated to cooperate with Wespath in order to protect the Plans' subrogation rights.

Wespath does not provide any health care Services and therefore cannot guarantee any results or outcomes. Health care Providers and vendors are independent contractors in private practice and are neither employees nor agents of Wespath. The availability of any particular Provider cannot be guaranteed, and Provider network composition is subject to change.

If you are a plan Participant, call the number on your ID Card for more information about the Plan in which you are enrolled.

Services are provided by Blue Cross and Blue Shield of Illinois, a licensee of the Blue Cross Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, and OptumRx. Blue Cross and Blue Shield of Illinois and OptumRx provide administrative claims payment Services only and do not assume any financial risk or obligation with respect to Claims.

Preferred Provider Medical and Behavioral Health Benefits—The Schedules

THE SCHEDULE—B1000

For You and Your Dependents
This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the BlueCross Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting "BlueCross BlueShield," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance
The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Under this plan, for In-Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $1,000 per person deductible and a $2,000 per family deductible. For In-Network Provider benefits, if the HQ requirement is not satisfied, there is a $1,250 per person deductible, and a $2,500 per family deductible. For Out-of-Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $2,000 per person deductible and a $4,000 per family deductible. For Out-of-Network Provider benefits, if the HQ requirement is not satisfied, there is a $2,250 per person deductible and a $4,500 per family deductible.

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible	*If satisfied HealthQuotient (HQ) requirement* • $1,000 per person *If did not satisfy HQ requirement* • $1,250 per person	*If satisfied HQ requirement* • $2,000 per person *If did not satisfy HQ requirement* • $2,250 per person
Family Deductible	*If satisfied HQ requirement* $2,000 per family *If did not satisfy HQ requirement* • $2,500 per family After Network Provider Deductibles totaling $2,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $4,000 per family *If did not satisfy HQ requirement* $4,500 per family After Non-Network Provider Deductibles totaling $4,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	• $5,000 per person •	• $10,000 per person
Out-of-Pocket Maximums • Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	• $10,000 per family After Network Provider Out-of-Pocket Expenses totaling $10,000 or $11,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.	• $20,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $20,000 or $22,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy plan, and behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission Co-payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Co-payments, the Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 60% (not subject to the deductible) for all services (office visits, exams and tests) up to reasonable and customary amount.
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 60% (not subject to the deductible) for all services (office visits, exams, and tests) up to reasonable and customary amount • Plan pays 60% (not subject to the deductible)

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing • Primary Care Physician Office Visit • Specialist Physician Office Visit • Outpatient facility • Independent lab and X-Ray Facility	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment • Plan pays 80% after the Deductible • Plan pays 80% after the deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Inpatient Hospital Facility Services • Semi-private room and board • Private room and board • Special care units (ICU/CCU room and board)	Plan pays 80% after the Deductible • Limited to the Hospital's negotiated rate for a semi-private room • Limited to the Hospital's negotiated rate for a semi-private room • Limited to the Hospital's negotiated rate	$200 Co-payment per admission then the Plan pays 60% after the Plan deductible • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Second Opinions Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 100% after a $200 Co-payment* per visit** • Plan pays 100% after a $100 Co-payment* per visit** • Plan pays 80% after Deductible ** Waived if admitted* ***If not a true emergency as defined in the Plan, the Plan pays 80% after the Deductible.*	• Plan pays 100% after a $30 Co-payment per visit** • Plan pays 100% after a $50 Co-payment per visit** • Plan pays 100% after a $200 Co-payment* per visit** • Plan pays 100% after a $100 Co-payment* per visit ** • Plan pays 80% after Deductible ** Waived if admitted* *** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible.*
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the Plan deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate	• $200 Co-payment per admission then the Plan pays 60% after the Plan deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes:		
• Physical Therapy	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Occupational Therapy	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Speech Therapy	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
Alternative Therapy Includes:		
• Chiropractic Care	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Massage Therapy	• Plan pays 50%, not subject to the Deductible	• Plan pays 50%, not subject to the Deductible
• Acupuncture	• Plan pays 50%, not subject to the Deductible	• Plan pays 50%, not subject to the Deductible
• Naprapathy	• Plan pays 50%, not subject to the Deductible	• Plan pays 50%, not subject to the Deductible
Coverage for chiropractic, naprapathy, and acupuncture is limited to 35 combined visits per calendar year.		
Maternity		
• Initial visit to confirm pregnancy	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery	• Plan pays 100% for prenatal care (except for ultrasounds) and plan pays 80% Co-insurance after Deductible for ultrasounds and subsequent eligible physician charges	• Plan pays 60% after the Deductible
• Facility Charges (Inpatient Hospital, birthing center)	• Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	• Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Family Planning Office visits including tests and counseling		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
• Outpatient Contraceptives Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy (excluding reversals)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services *Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.*	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 80% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 80% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum	• $10,000 per transplant; any daily limitation is subject to IRS regulations	

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Durable Medical Equipment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 100% after a $50 Co-payment • Plan pays 50% up to $3,000 every 24 months, (no Deductible)	• Plan pays 60% after the Deductible • Plan pays 50% up to $3,000 every 24 months, (no Deductible)
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 100% after a $50 Co-payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment)		
• Office Visit	• Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Licensed Dietitian Office Visit	Plan pays 100% after a $30 Co-payment	Plan pays 60% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	$15 co-payment then plan pays 100%	$15 co-payment then plan pays 100% of provider billed charges for office visits
Mental Health Inpatient Services	Plan pays 80% after deductible	$200 copayment then Plan pays 60% after deductible
Substance Abuse Outpatient Office Visits	$15 co-payment then plan pays 100% for office visits	$15 co-payment then the plan pays 100% of provider billed for office visit.
Substance Abuse Inpatient Services	Plan pays 80% after deductible	$200 copayment then Plan pays 60% after deductible
Other Mental Health and Substance Abuse Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible

THE SCHEDULE—HRA PLAN: C2000 WITH HRA

General Overview

An HRA Plan is a type of health insurance plan that allows a participant to use a health reimbursement account (HRA), explained below, to pay certain health care expenses directly, while a higher-deductible health plan protects the participant from high cost medical expenses.

An employer- /plan-funded health reimbursement arrangement (HRA, also called a health reimbursement account) is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. If a participant does not use all HRA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds. If a participant terminates from The United Methodist Church, the HRA balance is available for 365 days unless exhausted earlier. Any remaining HRA balances after 365 days from termination are forfeited.

HRA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. To be eligible, the participant must satisfy the retiree eligibility rules of his/her plan sponsor (conference or employer). The HRA balance will be available for the participant's use even if the plan sponsor does not sponsor retiree health coverage through HealthFlex.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HRA funds.

Participants may combine a health care FSA with an HRA. Based on the plan design, the FSA always pays first; then the HRA pays. FSA dollars are subject to the IRS "use it or lose it" rule, so you risk losing your unspent FSA dollars over $500 at the end of a plan year. In contrast, HRA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the BlueCross Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting "BlueCross BlueShield," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance

The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles

Under this plan, for Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $2,000 per person deductible and a $4,000 per family deductible. For Network Provider benefits, if the HQ requirement is not satisfied, there is a $2,250 per person deductible, and a $4,500 per family deductible. For Non-Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $3,000 per person deductible and a $6,000 per family deductible. For Non-Network Provider benefits, if the HQ requirement is not satisfied, there is a $3,250 per person deductible and a $6,500 per family deductible.

Co-payments are expenses to be paid by you or your Dependent for covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible	*If satisfied HQ requirement* • $2,000 per person *If did not satisfy HQ requirement* • $2,250 per person	*If satisfied HQ requirement* • $3,000 per person *If did not satisfy HQ requirement* • $3,250 per person
Family Deductible	*If satisfied HQ requirement* • $4,000 per family *If did not satisfy HQ requirement* • $4,500 per family After Network Provider Deductibles totaling $4,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $6,000 per family *If did not satisfy HQ requirement* • $6,500 per family After Non-Network Provider Deductibles totaling $6,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$6,000 per person	$12,000 per person
• Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$12,000 per family After Network Provider Out-of-Pocket Expenses totaling $12,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.	$24,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $24,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Coinsurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy plan and the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-

payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 60% (not subject to the deducible) for all services (office visits, exams, and tests) up to reasonable and customary amount
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 60% (not subject to the deductible) for all services (office visits, exams, and tests), up to reasonable and customary amount. • Plan pays 60% (not subject to the Deductible)

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing		
• Primary Care Physician Office Visit	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician Office Visit	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Outpatient Facility	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Independent Lab and X-ray Facility	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Inpatient Hospital Facility Services	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating room, Recovery room, Procedure room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Second Opinions Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	 • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	 • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	 • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after Deductible	 • Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible * • Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible* • Plan pays 80% after Deductible ** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider

Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the deductible
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Maximum: None	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate	• $200 Co-payment per admission then the Plan pays 60% after the deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes:		
• Physical Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Occupational Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Speech Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Alternative Therapy Includes:		
• Chiropractic Care	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Massage Therapy	• Plan pays 50% (not subject to the deductible)	• Plan pays 50% (not subject to the deductible)
• Acupuncture	• Plan pays 50% (not subject to the deductible)	• Plan pays 50% (not subject to the deductible)
• Naprapathy *Coverage for chiropractic, naprapathy, and acupuncture is limited to 35 combined visits per calendar year.*	• Plan pays 50% (not subject to the deductible)	• Plan pays 50% (not subject to the deductible)
Maternity		
• Initial Visit to Confirm Pregnancy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery	• Plan pays 100% for prenatal care (except for ultrasounds) and plan pays 80% Co-insurance after Deductible for ultrasounds and subsequent eligible physician charges	• Plan pays 60% after the Deductible
• Facility Charges (Inpatient Hospital, birthing center)	• Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	• Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Family Planning Office Visits including Tests and Counseling		
• Primary Care Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Outpatient Contraceptives Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy (excluding reversals)		
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.		
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 80% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 80% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum	• $10,000 per transplant; any daily limitation is subject to IRS regulations	
Durable Medical Equipment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 80% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months	• Plan pays 60% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Licensed Dietitian Office Visit	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	Plan pays 80% not subject to the deductible	Plan pays 80% of provider billed charges for office visits, not subject to the deductible
Mental Health Inpatient Services	Plan pays 80% after deductible	$200 Co-payment, then Plan pays 60% after deductible
Substance Abuse Outpatient Office Visits	Plan pays 80% not subject to the deductible	Plan pays 80% of provider billed charges for office visits, not subject to the deductible
Substance Abuse Inpatient Services	Plan pays 80% after deductible	$200 Co-payment then Plan pays 60% after deductible
Other Mental Health and Substance Abuse Outpatient Services	Plan pays 80% after deductible	Plan pays 80% after deductible

THE SCHEDULE—HRA PLAN: C3000 WITH HRA

General Overview

An HRA Plan is a type of health insurance plan that allows you as a participant to use a health reimbursement account (HRA), explained below, to pay certain health care expenses directly, while a high-deductible health plan protects the participant from catastrophic medical expenses.

An employer- /plan-funded health reimbursement arrangement (HRA, also called a health reimbursement account) is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. If a participant does not use all HRA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds. If a participant terminates from The United Methodist Church, the HRA balance is available for 365 days unless exhausted earlier. Any remaining HRA balances after 365 days from termination are forfeited.

HRA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. To be eligible, the participant must satisfy the retiree eligibility rules of both HealthFlex and his/her plan sponsor (conference or employer). The HRA balance will be available for the participant's use even if the plan sponsor does not sponsor retiree health coverage through HealthFlex.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HRA funds.

Participants may combine a health care FSA with an HRA. Based on the plan design, the FSA always pays first; then the HRA pays. FSA dollars are subject to the IRS "use it or lose it" rule, so you risk losing your unspent FSA dollars over $500 at the end of a plan year. In contrast, HRA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the BlueCross Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting "BlueCross BlueShield," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance

The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles

Under this plan, for Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $3,000 per person deductible and a $6,000 per family deductible. For Network Provider benefits, if the HQ requirement is not satisfied, there is a $3,250 per person deductible and a $6,500 per family deductible. For Non-Network Provider benefits, if the HealthQuotient (HQ) requirement is satisfied, there is a $4,500 per person deductible and a $9,000 per family deductible. For Non-Network Provider benefits, if the HQ requirement is not satisfied, there is a $4,750 per person deductible and a $9,500 per family deductible.

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible	*If satisfied HQ requirement* • $3,000 per person *If did not satisfy HQ requirement* • $3,250 per person	*If satisfied HQ requirement* • $4,500 per person • *If did not satisfy HQ requirement* • $4,750 per person
Family Deductible	*If satisfied HQ requirement* • $6,000 per family *If did not satisfy HQ requirement* $6,500 per family After Network Provider Deductibles totaling $6,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $9,000 per family *If did not satisfy HQ requirement* • $9,500 per family After Non-Network Provider Deductibles totaling $9,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$6,500 per person	$13,000 per person
• Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$13,000 per family After Network Provider Out-of-Pocket Expenses totaling $13,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$26,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $26,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy and the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Plan pays 30% after the Deductible • Plan pays 30% after the Deductible
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 30% (not subject to the deductible) for all services (office visits, exams, and tests) up to reasonable and customary amount.
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 30% for all services (office visits, exams, and tests) up to reasonable and customary amount • Plan pays 30% (not subject to the Deductible)

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing		
• Primary Care Physician Office Visit	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
• Specialist Physician Office Visit	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
• Outpatient Facility	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
• Independent Lab and X-ray Facility	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
Inpatient Hospital Facility Services	Plan pays 50% after the Deductible	$200 Co-payment per admission, then the Plan pays 30% after the deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating room, Recovery room, Procedure room and Treatment	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Second Opinions Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	 • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	 • Plan pays 30% after the Deductible • Plan pays 30% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	 • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after Deductible	 • Plan pays 50% after the Deductible* • Plan pays 50% after the Deductible * • Plan pays 50% after the Deductible* • Plan pays 50% after the Deductible* • Plan pays 50% after Deductible ** If not a true emergency as defined in the Plan, the Plan pays 30% after the Deductible*

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 50% after the Deductible	$200 Co-payment per admission, then the Plan pays 30% after the Deductible
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Plan pays 30% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Private Duty Nursing	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Maximum: None	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Limited to the hospice facility's negotiated rate	• $200 Co-payment per admission, then the Plan pays 30% after the deductible • Plan pays 30% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 50% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 50% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 30% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 30% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical Therapy • Occupational Therapy • Speech Therapy *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI).*	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Plan pays 30% after the Deductible • Plan pays 30% after the Deductible
Alternative Therapy Includes: • Chiropractic Care • Massage Therapy • Acupuncture • Naprapathy *Coverage for chiropractic, naprapathy, and acupuncture is limited to 35 combined visits per calendar year.*	• Plan pays 50% after the Deductible • Plan pays 50% (not subject to the deductible) • Plan pays 50% (not subject to the deductible) • Plan pays 50% (not subject to the deductible)	• Plan pays 30% after the Deductible • Plan pays 50% (not subject to the deductible) • Plan pays 50% (not subject to the deductible) • Plan pays 50% (not subject to the deductible)
Maternity • Initial Visit to Confirm Pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 50% after the Deductible • Plan pays 100% for prenatal care (except for ultrasounds) and plan pays 50% Co-insurance after Deductible for ultrasounds and subsequent eligible physician charges • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn)	• Plan pays 30% after the Deductible • Plan pays 30% after the Deductible • Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only) • Inpatient Facility • Outpatient Facility • Physician's Services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 30% after the Deductible
Family Planning Office Visits including Tests and Counseling • Primary Care Physician • Specialist Physician • Outpatient Contraceptives Services	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Plan pays 30% after the Deductible • Plan pays 30% after the Deductible
Surgical Sterilization Procedures for Vasectomy (excluding reversals) • Inpatient facility • Outpatient facility • Physician's services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 30% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
• Specialist Physician	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible
Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.		
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 50% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 50% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• Plan pays 50% after the Deductible	• Not covered
• Travel services maximum	• $10,000 per transplant; any daily limitation is subject to IRS regulations	
Durable Medical Equipment	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 50% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months	• Plan pays 30% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 50% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 30% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 50% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible	• Plan pays 30% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 30% after the Deductible
Licensed Dietitian Office Visit	Plan pays 50% after the Deductible	Plan pays 30% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	Plan pays 50% not subject to the deductible	Plan pays 50% of provider billed charges for office visits, not subject to the deductible
Mental Health Inpatient Services	Plan pays 50% after deductible	$200 Co-payment, then Plan pays 30% after deductible
Substance Abuse Outpatient Office Visits	Plan pays 50% not subject to the deductible	Plan pays 50% not subject to the deductible
Substance Abuse Inpatient Services	Plan pays 50% after deductible	$200 Co-payment, then Plan pays 30% after deductible
Other Mental health and Substance Abuse Outpatient Services	Plan pays 50% after deductible	Plan pays 50% after deductible

THE SCHEDULE—HSA PLAN: H1500 WITH HSA

General Overview

An HSA Plan is an IRS qualified high-deductible health plan that protects the participant from high cost medical expenses and allows you as a participant to use a health savings account (HSA), explained below, to pay certain health care expenses directly.

An employer- /plan-funded health savings account (HSA) is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. Participants may also contribute on a pre-tax basis to the HSA. If a participant does not use all HSA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds. There is an annual limit applicable to HSAs ($3,550 for single coverage in 2020 and $7,100 for family coverage in 2020). If the participant is age 55 or older, he or she can contribute an additional $1,000 in 2020. HSA eligibility, contribution limits and use of the HSA are governed by the Internal Revenue Code.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HSA funds. HSA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. In addition, HSAs may be used for non-eligible medical expenses, but a tax penalty may apply.

Participants who are no longer in a qualified HSA Plan through HealthFlex are not eligible to make or receive additional contributions to their HSA. However, their HSA balance will remain available to use until it is exhausted.

Participants may combine a health care FSA with an HSA. The health care FSA will be a limited-use FSA and can only be used for dental and vision expenses until the participant notifies WageWorks that the IRS-defined deductible has been met. When the IRS-defined deductible has been met, the FSA can be used for all eligible health care expenses (2020) IRS defined deductible: $1,400 individual, $2,800 family). Based on the plan design, the FSA always pays first; then the HSA pays. FSA dollars are subject to the IRS “use it or lose it” rule, so you risk losing your unspent FSA dollars at the end of a plan year. In contrast, HSA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the BlueCross Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting “BlueCross BlueShield,” or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance
The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Under this plan, for In-Network Provider benefits, there is a $1,500 per person deductible and a $3,000 per family deductible. For Out-of-Network Provider benefits, there is a $2,500 per person deductible and a $5,000 per family deductible. The HealthFlex HSA Plan has a deductible (combined medical, pharmacy and behavioral health) that you must meet before the plan pays any medical, pharmacy or behavioral health benefits other than preventive care. If two or more individuals are covered, you must meet the full family deductible before the plan pays benefits (individual deductible is not embedded).

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It only applies for participant-only coverage.	*If satisfied HQ requirement* • $1,500 per person *If did not satisfy HQ requirement* • $1,750 per person	*If satisfied HQ requirement* • $2,500 per person *If did not satisfy HQ requirement* • $2,750 per person
Family Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It applies whenever two or more individuals are covered by the plan.	*If satisfied HQ requirement* • $3,000 per family *If did not satisfy HQ requirement* • $3,500 per family After Network Provider Deductibles totaling $3,000 (or higher) have been applied in a Calendar Year for either: • you, • your Dependents, or • you and your Dependents your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $5,000 per family *If did not satisfy HQ requirement* • $5,500 per family After Non-Network Provider Deductibles totaling $5,000 (or higher) have been applied in a Calendar Year for either: • You, • your Dependents, or • you and your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$6,000 per person	$12,000 per person
• Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$12,000 per family After Network Provider Out-of-Pocket Expenses totaling $12,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$24,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $24,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy and the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission Co-payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 60% (not subject to the deductible) for all services (office visits, exams, and tests) up to reasonable and customary amount.
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 60% (not subject to the deductible) for all services (office visits, exams, and tests) up to reasonable and customary amount. • Plan pays 60% (not subject to the Deductible)

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing		
• Primary Care Physician Office Visit	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician Office Visit	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Outpatient Facility	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Independent Lab and X-ray Facility	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Inpatient Hospital Facility Services	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating room, Recovery room, Procedure room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Second Opinions Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	 • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	 • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	 • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after Deductible	 • Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible * • Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible* • Plan pays 80% after Deductible ** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the deductible
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Maximum: None	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate	$200 Co-payment per admission then the Plan pays 60% after the deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes:		
• Physical Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Occupational Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Speech Therapy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Alternative Therapy Includes:		
• Chiropractic Care	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Massage Therapy	• Plan pays 50% after the Deductible	• Plan pays 50% after the Deductible
• Acupuncture	• Plan pays 50% after the Deductible	• Plan pays 50% after the Deductible
• Naprapathy *Coverage for chiropractic, naprapathy, and acupuncture is limited to 35 combined visits per calendar year.*	• Plan pays 50% after the Deductible	• Plan pays 50% after the Deductible
Maternity		
• Initial Visit to Confirm Pregnancy	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery	• Plan pays 100% for prenatal care (except for ultrasounds) and plan pays 80% Co-insurance after Deductible for ultrasounds and subsequent eligible physician charges	• Plan pays 60% after the Deductible
• Facility Charges (Inpatient Hospital, birthing center)	• Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless readmitted)	• Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only) • Inpatient Facility • Outpatient Facility • Physician's Services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Family Planning Office Visits including Tests and Counseling • Primary Care Physician • Specialist Physician • Outpatient Contraceptives Services	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy (excluding reversals) • Inpatient facility • Outpatient facility • Physician's services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.		
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 80% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 80% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum	• $10,000 per transplant; any daily limitation is subject to IRS regulations	
Durable Medical Equipment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 80% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months	• Plan pays 60% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Licensed Dietitian Office Visit	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	Plan pays 80% after deductible	Plan pays 80% of provider billed charges for office visit, after deductible
Mental Health Inpatient Services	Plan pays 80% after deductible	$200 Co-payment, then Plan pays 60% after deductible
Substance Abuse Outpatient Office Visits	Plan pays 80% after deductible	Plan pays 80% of provider billed charges for office visit, after deductible
Substance Abuse Inpatient Services	Plan pays 80% after deductible	$200 Co-payment, then Plan pays 60% after deductible
Other Mental Health and Substance Abuse Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible

THE SCHEDULE—HSA PLAN: H2000 WITH HSA

General Overview

An HSA Plan is an IRS qualified high-deductible health plan that protects the participant from high cost medical expenses and allows you as a participant to use a health savings account (HSA), explained below, to pay certain health care expenses directly.

An employer- /plan-funded health savings account (HSA) is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. Participants may also contribute on a pre-tax basis to the HSA. If a participant does not use all HSA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds. There is an annual limit applicable to HSAs ($3,550 for single coverage in 2020 and $7,100 for family coverage in 2020). If the participant is age 55 or older, he or she can contribute an additional $1,000 in 2020). HSA eligibility, contribution limits and use of the HSA are governed by the Internal Revenue Code.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HSA funds. HSA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. In addition, HSAs may be used for non-eligible medical expenses, but a tax penalty may apply.

Participants who are no longer in a qualified HSA Plan through HealthFlex are not eligible to make or receive additional contributions to their HSA. However, their HSA balance will remain available to use until it is exhausted.

Participants may combine a health care FSA with an HSA. The health care FSA will be a limited-use FSA and can only be used for dental and vision expenses until the participant notifies WageWorks that the IRS-defined deductible has been met. When the IRS-defined deductible has been met, the FSA can be used for all eligible health care expenses (2020 IRS defined deductible: $1,400 individual, $2,800 family). Based on the plan design, the FSA always pays first; then the HSA pays. FSA dollars are subject to the IRS “use it or lose it” rule, so you risk losing your unspent FSA dollars at the end of a plan year. In contrast, HSA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the BlueCross Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting “BlueCross BlueShield,” or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance
The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Under this plan, for In-Network Provider benefits, there is a $2,000 per person deductible and a $4,000 per family deductible. If the HQ requirement is not satisfied, there is a $2,250 per person deductible and a $4,500 per family deductible. For Out-of-Network Provider benefits, there is a $3,000 per person deductible and a $6,000 per family deductible. If the HQ requirement is not satisfied, there is a $3,250 per person deductible and a $6,500 per family deductible. The HealthFlex HSA Plan has a deductible (combined medical, pharmacy and behavioral health) that you must meet before the plan pays any medical, pharmacy or behavioral health benefits. Certain eligible preventive and wellness services are covered at 100% and are not subject to the deductible. If two or more individuals are covered, you must meet the full family deductible before the plan pays benefits (individual deductible is not embedded).

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It only applies for participant-only coverage.	*If satisfied HQ requirement* • $2,000 per person *If did not satisfy HQ requirement* • $2,250 per person	*If satisfied HQ requirement* • $3,000 per person *If did not satisfy HQ requirement* • $3,250 per person
Family Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It applies whenever two or more individuals are covered by the plan.	*If satisfied HQ requirement* • $4,000 per family *If did not satisfy HQ requirement* • $4,500 per family After Network Provider Deductibles totaling $4,000 (or higher) have been applied in a Calendar Year for either: • you, • your Dependent(s), or • you and your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $6,000 per family *If did not satisfy HQ requirement* • $6,500 per family After Non-Network Provider Deductibles totaling $6,000 (or higher) have been applied in a Calendar Year for either: • you, • your Dependent(s), or • you and your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$6,500 per person	$13,000 per person
• Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$13,000 per family After Network Provider Out-of-Pocket Expenses totaling $13,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$26,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $26,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy and the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission Co-payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 50% (not subject to the deductible) for all services (office visits, exams, and tests) up to reasonable and customary amount
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 50% (not subject to the deductible)for all services (office visits, exams, and tests) • Plan pays 50% (not subject to the Deductible) up to reasonable and customary amount

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing		
• Primary Care Physician Office Visit	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
• Specialist Physician Office Visit	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
• Outpatient Facility	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
• Independent Lab and X-ray Facility	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
Inpatient Hospital Facility Services	Plan pays 70% after the Deductible	$200 Co-payment per admission then the Plan pays 50% after the deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating room, Recovery room, Procedure room and Treatment	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Second Opinions Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after Deductible	• Plan pays 70% after the Deductible* • Plan pays 70% after the Deductible * • Plan pays 70% after the Deductible* • Plan pays 70% after the Deductible* • Plan pays 70% after Deductible ** If not a true emergency as defined in the Plan, the Plan pays 50% after the Deductible*

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 70% after the Deductible	$200 Co-payment per admission then the Plan pays 50% after the deductible
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Private Duty Nursing	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Maximum: None	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Limited to the hospice facility's negotiated rate	• $200 Co-payment per admission then the Plan pays 50% after the deductible • Plan pays 50% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 70% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 70% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 50% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 50% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical Therapy • Occupational Therapy • Speech Therapy	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Alternative Therapy Includes: • Chiropractic Care • Massage Therapy • Acupuncture • Naprapathy *Coverage for chiropractic, naprapathy, and acupuncture is limited to 35 combined visits per calendar year.*	• Plan pays 70% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Maternity • Initial Visit to Confirm Pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 70% after the Deductible • Plan pays 100% for prenatal care (except for ultrasounds) and plan pays 70% Co-insurance after Deductible for ultrasounds and subsequent eligible physician charges • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only) • Inpatient Facility • Outpatient Facility • Physician's Services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 70% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible
Family Planning Office Visits including Tests and Counseling • Primary Care Physician • Specialist Physician • Outpatient Contraceptives Services	• Plan pays 70% after the Deductible • Plan pays 70% after the Deductible • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Plan pays 50% after the Deductible • Plan pays 50% after the Deductible
Surgical Sterilization Procedures for Vasectomy (excluding reversals) • Inpatient facility • Outpatient facility • Physician's services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 70% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
• Specialist Physician	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible
Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.		
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 70% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 70% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• Plan pays 70% after the Deductible	• Not covered
• Travel services maximum	• $10,000 per transplant; any daily limitation is subject to IRS regulations	
Durable Medical Equipment	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 70% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months	• Plan pays 50% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 70% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 70% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 70% after the Deductible	• Plan pays 50% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 50% after the Deductible
Licensed Dietitian Office Visit	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	Plan pays 70% after deductible	Plan pays 70% of provider billed charges for office visits, after deductible
Mental Health Inpatient Services	Plan pays 70% after deductible	$200 Co-payment, then Plan pays 50% after deductible
Substance Abuse Office Visits	Plan pays 70% after deductible	Plan pays 70% after deductible
Substance Abuse Inpatient Services	Plan pays 70% after deductible	$200 Co-payment, then Plan pays 50% after deductible
Other Mental Health and Substance Abuse Outpatient Services	Plan pays 70% after deductible	Plan pays 50% after deductible

THE SCHEDULE—HSA PLAN: H3000 WITH HSA

General Overview

An HSA Plan is an IRS qualified high-deductible health plan that protects the participant from high cost medical expenses and allows you as a participant to use a health savings account (HSA), explained below, to pay certain health care expenses directly.

The H3000 WITH HSA includes a health savings account (HSA), which can be used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. Participants may contribute on a pre-tax basis to the HSA (there is no employer/plan funding unless there is excess premium credit). If a participant does not use all HSA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds. There is an annual limit applicable to HSAs ($3,550 for single coverage in 2020 and $7,100 for family coverage in 2020). If the participant is age 55 or older, he or she can contribute an additional $1,000 in 2020). HSA eligibility, contribution limits and use of the HSA are governed by the Internal Revenue Code.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HSA funds. HSA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. In addition, HSAs may be used for non-eligible medical expenses, but a tax penalty may apply.

Participants who are no longer in a qualified HSA plan through HealthFlex are not eligible to make or receive additional contributions to their HSA. However, their HSA balance will remain available to use until it is exhausted.

Participants may combine a health care FSA with an HSA. The health care FSA will be a limited-use FSA and can only be used for dental and vision expenses until the participant notifies WageWorks that the IRS-defined deductible has been met. When the IRS-defined deductible has been met, the FSA can be used for all eligible health care expenses (2020) IRS-defined deductible: $1,400 individual, $2,800 family). Based on the plan design, the FSA always pays first; then the HSA pays. FSA dollars are subject to the “use it or lose it” rule, so you risk losing your unspent FSA dollars at the end of a plan year. In contrast, HSA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting Blue Cross and Blue Shield of Illinois website by logging into the HealthFlex/WebMD website at **wespath.org** and selecting “BlueCross BlueShield,” or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance
The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Under this plan, for In-Network Provider benefits, there is a $3,000 per person deductible and a $6,000 per family deductible. If the HQ requirement is not satisfied, there is a $3,250 per person deductible and a $6,500 per family deductible. For Out-of-Network Provider benefits, there is a $6,000 per person deductible and a $12,000 per family deductible. If the HQ requirement is not satisfied, there is a $6,250 per person deductible and a $12,500 family deductible. The HealthFlex HSA Plan has a deductible (combined medical, pharmacy and behavioral health) that you must meet before the plan pays any medical, pharmacy or behavioral health benefits. Certain eligible preventive and wellness services are covered at 100% and are not subject to the deductible. If two or more individuals are covered, you must meet the full family deductible before the plan pays benefits (individual deductible is not embedded).

Co-payments are expenses to be paid by you or your Dependent for covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	In-Network Provider	Out-of-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	In-Network Provider	Out-of-Network Provider
Individual Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It only applies for participant-only coverage.	*If HQ requirement satisfied* • $3,000 per person *If HQ requirement not satisfied* • $3,250 per person	*If HQ requirement satisfied* • $6,000 per person *If HQ requirement not satisfied* • $6,250 per person
Family Deductible The deductible is a combined medical, pharmacy and behavioral health plan deductible. It applies whenever two or more individuals are covered by the plan.	*If HQ requirement satisfied* • $6,000 per family *If HQ requirement not satisfied* • $6,500 per family After Network Provider Deductibles totaling $6,000 (or higher) have been applied in a Calendar Year for either: • you, • your Dependent(s), or • you and your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If HQ requirement satisfied* • $12,000 per family *If HQ requirement not satisfied* • $12,500 per family After Non-Network Provider Deductibles totaling $12,000 (or higher) have been applied in a Calendar Year for either: • you, • your Dependent(s), or • you and your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$6,500 per person	$13,000 per person
• Family Out-of-Pocket Maximum Out-of-Pocket Maximum is combined for medical, behavioral health and pharmacy	$13,000 per family After Network Provider Out-of-Pocket Expenses totaling $13,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$26,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $26,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan, pharmacy and the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission Co-payments for Out-of-Network Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How this Plan Works:

	In-Network Provider	Out-of-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown, up to the Reasonable and Customary Amount; participant may be billed the balance above the allowed Reasonable and Customary amount by the provider.

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's Office	• Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible • Plan pays 20% after the Deductible • Plan pays 20% after the Deductible
Well Child Care (under age 16) Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.*	Plan pays 20% for all services (office visits, exams, and tests) up to reasonable and customary amount
Well Adult Care (age 16 and over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider as part of the wellness exam.* • Plan pays 100%	• Plan pays 20% for all services (office visits, exams, and tests) up to reasonable and customary amount • Plan pays 20% up to reasonable and customary amount

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Pre-Admission Testing		
• Primary Care Physician Office Visit	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Specialist Physician Office Visit	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Outpatient Facility	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Independent Lab and X-ray Facility	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
Inpatient Hospital Facility Services	Plan pays 40% after the Deductible	$200 Co-payment per admission then the Plan pays 20% after the Plan deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating room, Recovery room, Procedure room and Treatment	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Second Opinions: Services can be sought on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	 • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible	 • Plan pays 20% after the Deductible • Plan pays 20% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan.*	 • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after Deductible	 • Plan pays 20% after the Deductible • Plan pays 20% after the Deductible • Plan pays 40% after the Deductible* • Plan pays 40% after the Deductible* • Plan pays 40% after Deductible* ** If not a true emergency as defined in the Plan, the Plan pays 20% after the Deductible*

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 40% after the Deductible	$200 Co-payment per admission then the Plan pays 20% after the Deductible
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 40% after the Deductible • Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible • Plan pays 20% after the Deductible
Home Health Care Calendar Year Maximum: 60 days	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Private Duty Nursing	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Maximum: None	• Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Limited to the hospice facility's negotiated rate	• $200 Co-payment per admission then the Plan pays 20% after the Deductible • Plan pays 20% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services	• Plan pays 40% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 40% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 20% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 20% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical Therapy • Occupational Therapy • Speech Therapy	• Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible • Plan pays 20% after the Deductible • Plan pays 20% after the Deductible
Alternative Therapy Includes: • Chiropractic Care • Massage Therapy • Acupuncture • Naprapathy *Coverage for chiropractic, naprapathy, acupuncture and massage therapy is limited to 35 combined visits per calendar year.*	• Plan pays 40% after the Deductible • Plan pays 40% after the deductible • Plan pays 40% after the deductible • Plan pays 40% after the deductible	• Plan pays 20% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible • Plan pays 40% after the Deductible
Maternity • Initial visit to confirm pregnancy • All subsequent prenatal visits. • Delivery and postnatal care • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 40% after deductible • Plan pays 100% for routine prenatal obstetrical office visits • Same as Plan's Inpatient Physician benefit • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	• Plan pays 20% after the Deductible • Plan pays 20% after the Deductible • Same as Plan's Inpatient Physician benefit • Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Abortion (Non-elective procedures only)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
Family Planning Office Visits including Tests and Counseling		
• Primary Care Physician	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Specialist Physician	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Outpatient Contraceptives Services	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
Surgical Sterilization Procedures for Vasectomy/ (excluding reversals)		
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's services	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
• Specialist Physician	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible
Maximum of 4 Assisted Reproductive Technologies (ART) procedures during lifetime.		
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Blue Distinction Transplant Center facility	• Plan pays 40% after the Deductible	• Not covered
• Blue Distinction Transplant Center Physician	• Plan pays 40% after the Deductible	• Not covered
• BCBS-approved facilities for Human Organ Transplant Programs	• $10,000 per transplant; any daily limitation is subject to IRS regulations	• Not covered
• Travel services maximum		
Durable Medical Equipment	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
External Prosthetic Appliances *This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.*	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (not bone anchored) (excludes replacement and repair)	• Plan pays 40% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months	• Plan pays 20% after the Deductible • Plan pays 50% after deductible, up to $3,000 every 24 months
Dental Care (Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 40% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 20% after the Deductible

Plan Pays:

Plan Feature	In-Network Provider	Out-of-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician Services	• Plan pays 40% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 40% after the Deductible	• Plan pays 20% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 20% after the Deductible
Licensed Dietitian Office Visit	Plan pays 40% after the Deductible	Plan pays 20% after the Deductible
Mental Health Office Visits Psychiatrist, Psychologist, other mental health professionals	Plan pays 40% after deductible	Plan pays 40% of provider billed charges for office visits, after deductible
Mental Health Inpatient Services	Plan pays 40% after deductible	$200 Co-payment, then Plan pays 20% after deductible
Substance Abuse Outpatient Office Visits	Plan pays 40% after deductible	Plan pays 40% of provider billed charges for office visit, after deductible
Substance Abuse Inpatient Services	Plan pays 40% after deductible	$200 Co-payment, then Plan pays 20% after deductible
Other Mental Health and Substance Abuse Outpatient Services	Plan pays 40% after deductible	Plan pays 20% after deductible

Prescription Drug Benefits Schedules

Prescription plans use the OptumRx Premium formulary. Each Medical Benefit Option noted above is paired with a prescription drug plan option, listed below.

B1000—THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits

- ***In-Network Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Out-of-Network Pharmacy:*** You or your Dependent must pay out of pocket for the Prescription Drugs and will be reimbursed for a portion of the cost of covered Prescription Drugs that equals what the plan would have paid at an In-Network Pharmacy for the Drug.

Maximum Out-of-Pocket Expenses

Maximum Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating Pharmacies.

Maximum Out-of-Pocket Expenses exclude non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, costs incurred at Retail Pharmacies for maintenance medications once the Retail Refill Allowance has been exceeded, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at an In-Network Pharmacy.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum.

Out-of-Pocket Maximum	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$5,000 per person per Calendar Year	None
Family	$10,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy or Walgreens by participating in the Walgreens Retail 90 program. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill, unless member is participating in the Walgreens Retail 90 program which allows 90-day maintenance prescriptions to be filled at Walgreens.
- ***Reimbursement for Out-of-Network Pharmacy or a Participant Pharmacy when no card is used*** is limited to the amount the Plan would have paid to an In-Network Pharmacy. If an In-Network Pharmacy is not available, a Claim must be filed on a paper form available from OptumRx; then 100% of the Allowable Amount will be reimbursed after any Co-Payments are met.

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $15 Co-payment per prescription	• See above
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 20% Co-payment per prescription. Minimum Co-payment: $20; Maximum Co-payment: $55	• See above
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $40; Maximum Co-payment: $110	• See above

***Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

OptumRx Home Delivery or Walgreens Pharmacy for Maintenance Medication (90-day supply)

Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	In-Network Pharmacy	Out-of-Network Pharmacy
Home-Delivered Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $35 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 20% Co-payment per prescription Minimum Co-payment: $50; Maximum Co-payment: $140	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $85; Maximum Co-payment: $240	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

C2000 WITH HRA AND C3000 WITH HRA—THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits

- ***In-Network Pharmacy***: You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Out-of-Network Pharmacy***: You or your Dependent must pay out of pocket for the Prescription Drugs and will be reimbursed for a portion of the cost of covered Prescription Drugs that equals what the plan would have paid at an In-Network Pharmacy for the Drug.

Maximum Out-of-Pocket Expenses

Maximum Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating Pharmacies.

Maximum Out-of-Pocket Expenses exclude non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, costs incurred at Retail Pharmacies for maintenance medications once the Retail Refill Allowance has been exceeded, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at an In-Network Pharmacy.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum.

Out-of-Pocket Maximum	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$6,000 per person per Calendar Year (when paired with **C2000 WITH HRA**) $6,500 per person per Calendar Year (when paired with **C3000 WITH HRA**)	None
Family	$12,000 per family per Calendar Year (when paired with **C2000 WITH HRA**) $13,000 per person per Calendar Year (when paired with **C3000 WITH HRA**)	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy or Walgreens by participating in the Walgreens Retail 90 program. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.

- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill, unless member is participating in the Walgreens Retail 90 program which allows 90-day maintenance scripts to be filled at Walgreens.
- ***Reimbursement for Out-of-Network Pharmacy or an In-Network Pharmacy when no card is used*** is limited to the amount the Plan would have paid an In-Network Pharmacy. If an In-Network Pharmacy is not available, a Claim must be filed on a paper form available from OptumRx; then 100% of the Allowable Amount reimbursed after any Co-Payments are met.

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs • Generic Drugs (Tier 1)	• Plan pays 100% after a $15 Co-payment per prescription	• See above
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $25; Maximum Co-payment: $65	• See above
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $50; Maximum Co-payment: $120	• See above

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

OptumRx Home Delivery or Walgreens Pharmacy for Maintenance Medication (90-day supply)

Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	In-Network Pharmacy	Out-of-Network Pharmacy
Home-Delivered Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $35 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 25% Co-payment per prescription Minimum Co-payment: $60; Maximum Co-payment: $150	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $95; Maximum Co-payment: $260	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

H1500 WITH HSA—THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits

- ***In-Network Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Out-of-Network Pharmacy:*** You or your Dependent must pay out of pocket for the Prescription Drugs and will be reimbursed for a portion of the cost of covered Prescription Drugs that equals what the plan would have paid at an In-Network Pharmacy for the Drug.
- ***Preventive Drug List:*** Drugs on OptumRx's preventive drug list are not subject to deductible. Co-payment/coinsurance immediately applies.

Calendar Year Deductible

Deductibles (for qualified high-deductible health plans) are expenses to be paid by you or your Dependent before the plan begins to pay for a portion of covered Prescription Drugs. The deductible is a combined deductible with medical and behavioral health expenses. If two or more individuals are covered in HealthFlex, you must meet the full family deductible before the plan pays benefits.

Deductible includes medical, behavioral health and pharmacy.

Deductibles	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$1,500*	Does not apply
Family	$3,000*	Does not apply

*Assumes completion of the HQ requirement. If HQ requirement is not satisfied: deductible is $250 higher for individual coverage and $500 higher for family coverage.

Maximum Out-of-Pocket Expenses
Maximum Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating Pharmacies.

Maximum Out-of-Pocket Expenses exclude non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, costs incurred at Retail Pharmacies for maintenance medications once the Retail Refill Allowance has been exceeded, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at an In-Network Pharmacy.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum.

Out-of-Pocket Maximum	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$6,000 per person per Calendar Year	None
Family	$12,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy or Walgreens by participating in the Walgreens Retail 90 program. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill, unless member is participating in the Walgreens Retail 90 program which allows 90-day maintenance scripts to be filled at Walgreens.
- ***Reimbursement for Out-of-Network Pharmacy or an In-Network Pharmacy when no card is used*** is limited to the amount the Plan would have paid to an In-Network Pharmacy. If an In-Network Pharmacy is not available, a Claim must be filed on a paper form available from OptumRx; then 100% of the Allowable Amount will be reimbursed after any Deductible and/or Co-Payment are met.

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs • Generic Drugs (Tier 1)	• After deductible, Plan pays 100% after $15 Co-payment per prescription	• See above
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 100% after 25% Co-payment per prescription. Minimum Co-payment: $25; Maximum Co-payment: $65	• See above
• Non-preferred Brand Name Drugs* (Tier 3)	• After deductible, Plan pays 100% after 30% Co-payment per prescription. Minimum Co-payment: $50; Maximum Co-payment: $120	• See above

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

OptumRx Home Delivery or Walgreens Pharmacy for Maintenance Medication (90-day supply)
Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	In-Network Pharmacy	Out-of-Network Pharmacy
Home-Delivered Drugs • Generic Drugs (Tier 1)	• After deductible, Plan pays 100% after a $35 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 100% after a 25% Co-payment per prescription Minimum Co-payment: $60; Maximum Co-payment: $150	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• After deductible, Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $95; Maximum Co-payment: $260	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

H2000 WITH HSA—THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits

- ***In-Network Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Out-of-Network Pharmacy:*** You or your Dependent must pay out of pocket for the Prescription Drugs and will be reimbursed for a portion of the cost of covered Prescription Drugs that equals what the plan would have paid at an In-Network Pharmacy for the Drug.
- ***Preventive Drug List:*** Drugs on OptumRx's preventive drug list are not subject to deductible. Co-payment/coinsurance immediately applies.

Calendar Year Deductible

Deductibles (for qualified high-deductible health plans) are expenses to be paid by you or your Dependent before the plan begins to pay for a portion of covered Prescription Drugs. The deductible is a combined deductible with medical and behavioral health expenses. If two or more individuals are covered in HealthFlex, you must meet the full family deductible before the plan pays benefits.

Deductible includes medical, behavioral health and pharmacy.

Deductibles	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$2,000*	Does not apply
Family	$4,000*	Does not apply

*Assumes completion of the HQ requirement; deductible is $250 higher for individual coverage and $500 higher for family coverage.

Maximum Out-of-Pocket Expenses

Maximum Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating Pharmacies.

Maximum Out-of-Pocket Expenses exclude non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, costs incurred at Retail Pharmacies for maintenance medications once the Retail Refill Allowance has been exceeded, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at an In-Network Pharmacy.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum.

Out-of-Pocket Maximum	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$6,500 per person per Calendar Year	None
Family	$13,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy or Walgreens by participating in the Walgreens Retail 90 program or Walgreens by participating in the Walgreens Retail 90 program. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill, unless member is participating in the Walgreens Retail 90 program which allows 90-day maintenance scripts to be filled at Walgreens.
- ***Reimbursement for Out-of-Network Pharmacy or an In-Network Pharmacy when no card is used*** is limited to the amount the Plan would have paid to an In-Network Pharmacy. If an In-Network Pharmacy is not available, a Claim must be filed on a paper form available from OptumRx; then 100% of the Allowable Amount will be reimbursed after any Deductible and/or Co-Payment are met.

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs		
• Generic Drugs (Tier 1)	• After deductible, Plan pays 100% after a $15 Co-payment per prescription	• See above
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $25; Maximum Co-payment: $65	• See above
• Non-preferred Brand Name Drugs* (Tier 3)	• After deductible, Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $50; Maximum Co-payment: $120	• See above

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

OptumRx Home Delivery or Walgreens Pharmacy for Maintenance Medication (90-day supply)
Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	In-Network Pharmacy	Out-of-Network Pharmacy
Home-Delivered Drugs		
• Generic Drugs (Tier 1)	• After deductible, Plan pays 100% after a $35 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 100% after a 25% Co-payment per prescription Minimum Co-payment: $60; Maximum Co-payment: $150	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• After deductible, Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $95; Maximum Co-payment: $260	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

H3000 WITH HSA—THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits

- ***In-Network Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Out-of-Network Pharmacy:*** You or your Dependent must pay out of pocket for the Prescription Drugs and will be reimbursed for a portion of the cost of covered Prescription Drugs that equals what the plan would have paid at an In-Network Pharmacy for the Drug.
- ***Preventive Drug List:*** Drugs on OptumRx's preventive drug list are not subject to deductible. Co-payment/coinsurance immediately applies.

Calendar Year Deductible

Deductibles (for qualified high-deductible health plans) are expenses to be paid by you or your Dependent before the plan begins to pay for a portion of covered Prescription Drugs. The deductible is a combined deductible with medical and behavioral health expenses. *If two or more individuals are covered in HealthFlex, you must meet the full family deductible before the plan pays benefits.*

Deductible includes medical, behavioral health and pharmacy

Deductibles	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$3,000*	Does not apply
Family	$6,000*	Does not apply

*Assumes completion of the HQ requirement. If HQ requirement is not completed, deductible is $250 higher for individual coverage and $500 higher for family coverage.

Maximum Out-of-Pocket Expenses

Maximum Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating Pharmacies.

Maximum Out-of-Pocket Expenses exclude non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, costs incurred at Retail Pharmacies for maintenance medications once the Retail Refill Allowance has been exceeded, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at an In-Network Pharmacy.

Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward one, *shared* Out-of-Pocket Maximum.

Out-of-Pocket Maximum	In-Network Pharmacy	Out-of-Network Pharmacy
Individual	$6,500 per person per Calendar Year	None
Family	$13,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy or Walgreens by participating in the Walgreens Retail 90 program. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill, unless member is participating in the Walgreens Retail 90 program which allows 90-day maintenance scripts to be filled at Walgreens.
- ***Reimbursement for Out-of-Network Pharmacy or a Participant Pharmacy when no card is used*** is limited to the amount the Plan would have paid to an In-Network Pharmacy. If an In-Network Pharmacy is not available, a Claim must be filed on a paper form available from OptumRx; then 100% of the Allowable Amount will be reimbursed after any Deductible and/or Co-Payment are met.

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs		
• Generic Drugs (Tier 1)	• After deductible, Plan pays 40%	• See above
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 40%	• See above
• Non-preferred Brand Name Drugs* (Tier 3)	• After deductible, Plan pays 40%	• See above

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

OptumRx Home Delivery or Walgreens Pharmacy for Maintenance Medication (90-day supply)
Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	In-Network Pharmacy	Out-of-Network Pharmacy
Home-Delivered Drugs (OptumRx Home Delivery)		
• Generic Drugs (Tier 1)	• After deductible, Plan pays 40% Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• After deductible, Plan pays 40% • After deductible, Plan pays 40%	• Not applicable • Not applicable

• Non-preferred Brand Name Drugs* (Tier 3)		

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

Notes to Schedule of Prescription Drug Benefits—All Plans

Coverage of Non-Sedating Antihistamines: Non-sedating antihistamine drugs are paid as Tier 3, regardless of the drug's Formulary status. This is a result of the drug, Claritin, being available over-the-counter. For example, if you prefer to take the medication Clarinex rather than buying Claritin over-the-counter, you will pay the Tier 3 Co-payment.

Retail Refill Allowance (RRA) Program: The Plan maintains a Retail Refill Allowance Program policy. This Program requires that you use the OptumRx home-delivery program (an OptumRx company) if you are prescribed a maintenance medication (long-term Prescription Drug), rather than refilling multiple prescriptions for the same Prescription Drug at a Retail Pharmacy.

Important: OptumRx Home Delivery (i.e., mail-order program) or a Walgreens Retail Pharmacy should be used for maintenance (long-term) medications. You can receive up to a 90-day supply of medication for one Co-payment through the Home Delivery or at a Walgreens Pharmacy. Prescriptions must be filled as prescribed by your Physician—refills cannot be combined to equal a 90-day supply—meaning your Physician must prescribe a 90-day supply of the drug(s). Please refer to *The Schedule of Prescription Drug Benefits* for details about Co-payments for pharmacy home-delivery or 90-day supplies from Walgreens. *If you submit a prescription for less than a standard 90-day supply of a Prescription Drug to OptumRx and OptumRx is able, in its reasonable judgment, to dispense such supply, you will be charged a Co-payment for a full 90-day supply of the Prescription Drug.*

In certain circumstances, you may not be required to use the mail-order program. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local Participating Retail Pharmacy (and are therefore exempt from the mandatory mail-order program provision outlined above). If you have a prescription for any of the following medications, the Plan allows you to receive multiple refills at your local Participating Retail Pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.
- Compounded medications, which must be filled at an approved compounding pharmacy.

Keep in mind that—with the exception of the drugs listed above—the Plan only allows for a total of three fills of a maintenance medication at a Participating Retail Pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan; you will have to pay the full price of the drug. Each retail fill can be for no more than a 30-day supply. **Note:** You are allowed a total of three fills, even if each is for less than 30 days.

Generic First Program: Generic medications may have unfamiliar names, but they are safe and effective. Generic medications and their Brand Name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity and quality as their Brand Name counterparts. For this reason, the Plan will cover only the cost of the equivalent Generic Drug if you purchase a Brand Name Drug when there is an equivalent Generic Drug available. You will be charged one amount equal to the Generic Drug Co-payment plus the cost difference between the Brand Name Drug and the Generic Drug. If you have questions or concerns about generic medication, speak to your Physician or your Pharmacist, and he or she will be able to help you.

Refilling OptumRx Home Delivery Prescriptions—Because it can take 7 to 11 days for your medications to be delivered via the home delivery program, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your Physician for another prescription for a 14-day supply that you can fill at your local Participating Retail Pharmacy (**note**: you will be responsible for paying any applicable Retail Pharmacy Co-payment).

Prescriptions Filled at an Out-of-Network Pharmacy—If you go to a Retail Pharmacy that is not part of the OptumRx network (an Out-of-Network Pharmacy), you must pay the full cost of the prescription and then submit a direct reimbursement Claim form to OptumRx. You will be reimbursed for the amount the medication would have cost the Plan at a Participating Retail Pharmacy minus the Co-payment you would have paid.

Additional Notes:

- Some prescriptions may require prior authorization. Please refer to the Prescription Drug Benefits section of this Benefit Booklet for further information.
- Deductibles and Co-payments for Prescription Drugs do not apply to the Plan Deductibles or Out-of-Pocket Maximums under the medical portion of the Plan.

Appendix A

CLAIMS ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claims Administrator hereby informs you that it has contracts with certain Providers (Administrator Providers) in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claims Administrator is a party, including all persons covered under the Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claims Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claims Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claims Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any Out-of-Pocket maximums or any maximum amounts of benefits payable by the Claims Administrator as described in this Benefit Booklet and the calculation of all required Deductible and Co-insurance amounts payable by you as described in this Benefit Booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage (ADP) applicable to your Claim or Claims. Wespath has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement between Wespath and the Claims Administrator. Neither Wespath nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claims Administrator's separate financial arrangements with Providers work, please consider the following example:

> *Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?*

You personally will have to pay the Deductible and Co-insurance amounts set out in this Benefit Booklet.

However, for purposes of calculating your Deductible and Co-insurance amounts, and whether you have reached any Out-of-Pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your Deductible and Co-insurance amounts, and whether you have reached any Out-of-Pocket or benefit maximums. Assuming you have already satisfied your Deductible, you will still have to pay the Co-insurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Co-insurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should

note that your 20% Co-insurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

After taking into account the Deductible and Co-insurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claims Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your Deductible has already been satisfied, and your Co-insurance is $140, then the Claims Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claims Administrator has a contract with the Hospital, the Claims Administrator will usually be able to satisfy the $860 bill that remains after your Co-insurance and Deductible by paying less than $860 to the Hospital, often substantially less than $860. The Claims Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claims Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor Wespath are entitled to any part of these savings.

OTHER BLUE CROSS AND BLUE SHIELD OF ILLINOIS SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BlueCard
The Claims Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois (Host Blue) may have contracts similar to the contracts described above with certain Providers (Host Blue Providers) in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider that does not have a contract with the Claims Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

Example:

Suppose you receive Covered medical Services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claims Administrator.

The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100. The Host Blue, in turn, forwards the claim to the Claims Administrator and indicates that the negotiated price for the covered service is $80. The Claims Administrator would then base the amount you must pay for the service—the amount applied to your Deductible, if any, and your Co-insurance percentage—on the $80 negotiated price, not the $100 billed charge. So, for example, if your Co-insurance were 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

Please note: *The Co-insurance percentage in the above example is for illustration purposes only.* The example assumes that you have met your Deductible and that there are no Co-payments associated with the service rendered. Your Deductible(s), Co-insurance and Co-payment(s) are specified in this Benefit Booklet.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be

realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claims Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

SERVICING PLANS

In some instances, the Claims Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claims Administrator's behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claims Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claims Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (Servicing Plan Providers) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claims Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required Deductible and Co-insurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider's eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claims Administrator—whichever is lower.

Often, the agreed-upon cost is a simple discount. Sometimes, however, the agreed-upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Co-insurance is calculated. When Covered Services are rendered in those states, the Co-insurance amount will be calculated using the state's statutory method.

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