



# Wespath

BENEFITS | INVESTMENTS

a general agency of The United Methodist Church



## HealthFlex Benefits Booklet

Including Medical, Behavioral Health, Pharmacy,  
Dental, Vision and Health/Reimbursement  
Account Benefit Options

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**Note:** If any discrepancy exists between this Benefit Booklet and the terms and conditions set forth in the official plan document of the HealthFlex Plan or the summary plan description (SPD), the terms of the official plan document and SPD shall govern.

The plan described in this document (“HealthFlex” or the “Plan”) is maintained and administered by Wespath. The Plan is self-funded (or self-insured) (except with respect to certain vision and dental benefits, which are fully insured).

This document contains only a partial, general description of the Plan. 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.

Wespath and plan sponsors, as applicable, retain the right to amend, terminate or modify the terms of the Plan, as well as any Plan Sponsor provided health subsidy, at any time, without notice and for any reason.

Not all benefits under the Plan are available in all areas of the United States. The Plan does 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 Plan are subject to applicable laws, regulations, and policies. All benefits are subject to coordination of benefits provisions. The Plan is 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 Plan. The Plan may assert this right independently of a plan Participant, and such Participant is obligated to cooperate with Wespath in order to protect the Plan’s subrogation rights.

Wespath does not provide any health care services, and therefore cannot guarantee any results or outcomes. Health care Providers and vendors 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 benefit option(s) in which you are enrolled.

## WELCOME

Wespath has prepared this Benefit Booklet to help you understand your HealthFlex benefits. Please read this booklet 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 HealthFlex Plan, is maintained for the benefit of clergy and lay employees (and their eligible Dependents) of The United Methodist Church and related organizations.

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 health care benefits balanced with financial stewardship on behalf of all Participants. We strive to ensure clergy and lay employees across the denomination and related organizations 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, optimizing plan designs to promote consumerism, investing in well-being to promote the health of our participants, 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 by reviewing all of your health and well-being benefits at [BenefitsAccess.org](https://BenefitsAccess.org) or by asking your Physician.

### 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.

### **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 and Care Coordinators**

Under the terms of the administrative services agreements with the Claims Administrators and Care Coordinators, Wespath has delegated the administrative duties noted in the table below. Wespath, as the Plan Administrator, pays for these benefits through banking arrangements with the Claims Administrators. Wespath has also contractually delegated certain fiduciary duties to the Claims Administrators and Care Coordinators. Specifically, Wespath has delegated the fiduciary duties with respect to administering claims and hearing appeals of claim denials to the parties below as contracted fiduciaries. The Claims Administrators and Care Coordinators 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 and Care Coordinators, as noted on the following page.

HealthFlex Claims Administrators:

<b>Types of Claims Administered</b>	<b>Claim Administrator</b>
First-Level Medical and Behavioral Health Claims	<b>Blue Cross/ Blue Shield of IL</b> 300 E. Randolph St. Chicago, IL 60601 <a href="http://bcbsil.com">bcbsil.com</a> <b>(866) 804-0976T</b>
Medical and Behavioral Health Appeals	<b>Quantum Health - Appeals Department</b> 5240 Blazer Parkway Dublin, OH 43017 <b>Fax: 1-877-498-3681</b>
Pharmacy Benefits	<b>OptumRx</b> 1600 McConnor Parkway Schaumburg, IL 60172 <a href="http://OptumRx.com">OptumRx.com</a> <b>(855) 239-8471</b>
Dental Benefits	<b>Cigna Dental</b> P.O. Box 188037 Chattanooga, TN 37422 <b>(800) 244-6224</b>
Vision Benefits	<b>VSP Vision Care</b> 200 S. Wacker Drive Chicago, IL 60606 <b>(800) 877-7195</b>
Health and Reimbursement Accounts (FSA, HRA, HSA)	<b>HealthEquity/WageWorks</b> 15 West Scenic Pointe Drive Draper, UT 84020 <b>(844) 341-6998</b>

### **Rights are Non-Assignable**

A Covered Person's Claim for benefits under this Plan is expressly non-assignable and nontransferable 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 the 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.

An attempted assignment is not a grant of authority to act on a claimant's behalf in appealing a benefit determination under the Plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the Plan.

### **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.

### **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 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. Certain vision and dental benefits are fully insured.



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.

Please refer to the [HealthFlex Summary Plan Description](#) for additional information regarding termination of coverage and Continuation Coverage.

### **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, Wespeth employees and Plan representatives and agents (such as Blue Cross and Blue Shield of Illinois, Quantum Health, OptumRx and others) may not release Protected Health Information, known as PHI, to a Participant's 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. Wespeth'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, [BenefitsAccess.org](#).

Wespeth 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 will 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 Wespeth, such as the Claims Administrator, may access PHI, subject to the rules of HIPAA and the privacy policies of Wespeth, as part of their day-to-day function of administering the Plan.



If you have questions about the benefit plans administered by Wespath, please contact us.

For more information, please visit [BenefitsAccess.org](https://BenefitsAccess.org). Or you may contact the Wespath Health and Wellness Team at the address or phone number below:

**HealthFlex Plan**

Wespath Benefits and Investments  
1901 Chestnut Ave.  
Glenview, IL 60025  
**(800) 851-2201**

**Wespath welcomes you to HealthFlex and looks forward to serving you**



## ELIGIBILITY AND ACCESSING BENEFITS

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.

### The Schedule

The Schedule of Benefits is a brief outline of your benefits payable under the Plan for each type of benefit option. There is a schedule of benefits in each section, as well as a full description of each benefit, in the appropriate sections listed in the *Table of Contents*.

### Your ID Card

For Medical, Pharmacy and Behavioral Health Benefits, 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. The Dental HMO Benefit Option has a separate ID card that you will receive. Other Dental Benefit Options and the Vision Benefits Have ID cards that are available electronically and have necessary identification information.

### 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.

### 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.

### Making Your Benefit Elections

If you are eligible for the Plan, you must elect your Benefit Options when you initially become eligible. You may change your elections annually, during the Annual Election period and/or if you experience a Life Status Event change. For details, please consult the *HealthFlex Summary Plan Description*.

### 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.
- You or your employer fail to pay Required Contributions and you are terminated from the Plan.

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 last day of the month of the individual's last day of eligibility.

### Special Rules

There are certain circumstances where you or your Dependent might be eligible for coverage where you otherwise would not.

#### FAMILY LEAVE

If you are a clergy Employee placed on family leave or maternity or paternity leave pursuant to ¶353.2b) or ¶355 of *The Book of Discipline*, you may continue to participate in the Plan for a period up to 12 weeks.

#### FMLA

If you are a lay Employee of a Plan Sponsor that is subject to the terms of the Family and Medical Leave Act (FMLA) and you take an FMLA covered leave, or you are a clergy Participant and you are placed on medical leave, a family leave or a maternity/paternity leave as defined in *The Book of Discipline*, subject to the requirements of §125 of the Code (the cafeteria plan rules) and any other applicable laws and regulations and the personnel policies of your Plan Sponsor, the following rules generally will apply:

- You may maintain your medical, pharmacy, dental and vision benefits, provided that your Plan Sponsor permits continued coverage under its policies and rules. You may maintain your Health Care Flexible Spending Account (health care FSA) and Dependent Care Flexible Spending Account (dependent care FSA) as if you were a salaried Active Participant, for three (3) calendar months from the end of the month in which you first went from salaried to medical leave status (i.e., began the FMLA leave). You can pay the premium conversion and salary-reduction amounts due for that period: 1) in full on a pre-tax basis either before the medical leave or upon return from medical leave (if within the three-month period), or 2) on an after-tax basis during the medical leave.
- If you continue to receive salary, Required Contributions and salary-reduction amounts may be deducted on a pre-tax basis during the leave.
- At the end of the three-month period described above, Wespath will terminate any Health Care FSA or Dependent Care FSA you might have. You have 90 days from the later of 1) the last day on which you received salary or 2) the last day of the 3-month period described above if you maintained your FSA when your medical leave began in which to submit claims for reimbursement from your FSA for claims incurred on or before the last day on which you received salary. Claims submitted after this 90-day run-out period will not be paid, and any amounts remaining in FSA accounts after such period are forfeited to the Plan.

**MEDICAL CHILD SUPPORT ORDERS**

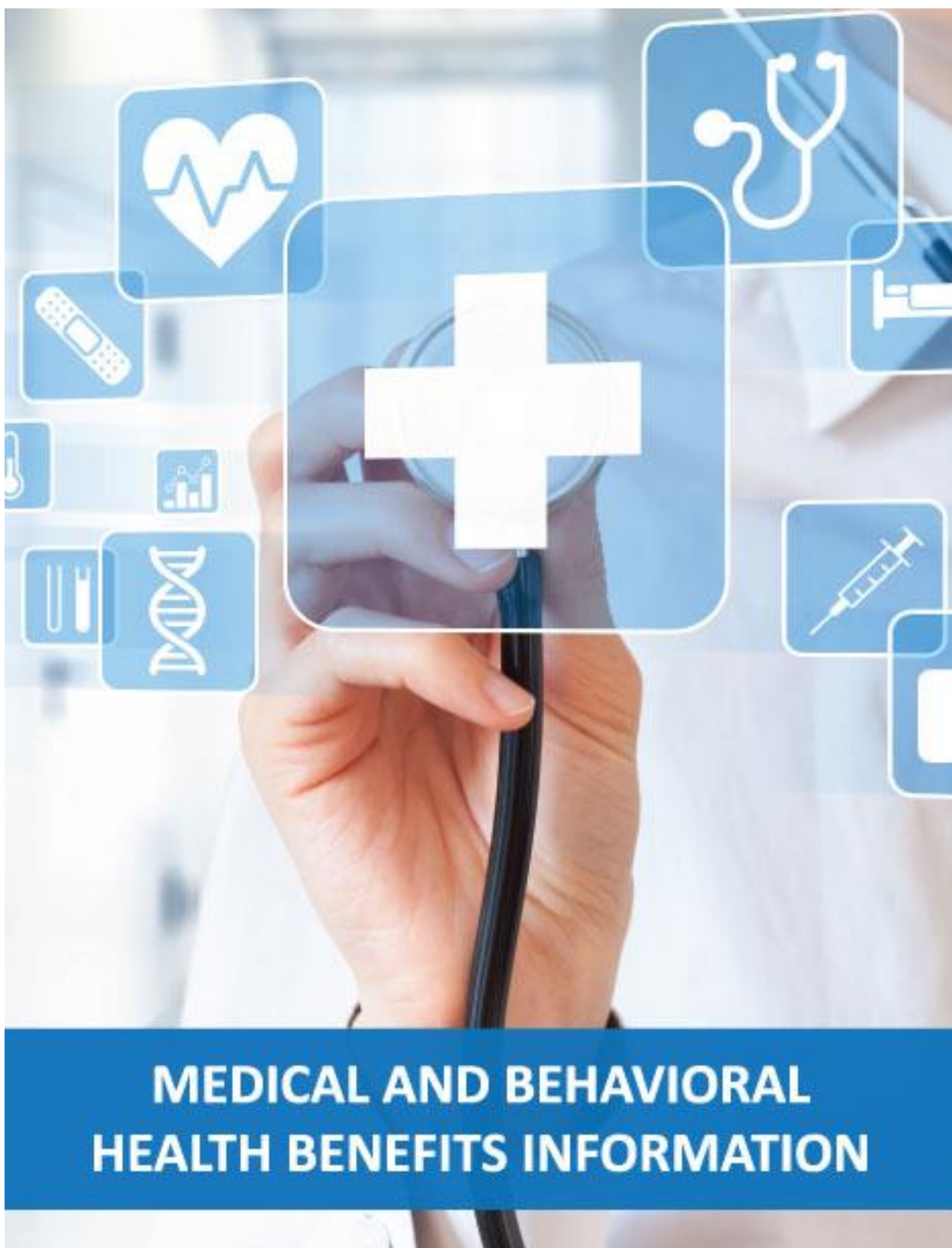
Wespath may determine that the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order (QMCSO), as defined in §609 of ERISA or other medical support order, including a National Medical Support Notice issued pursuant to the Child Support Performance and Incentive Act of 1998, that Wespath reasonably determines applies to the Plan, relating to the child of a Participant. Wespath or its agent shall pay benefits covered by a QMCSO directly to the child or to the child's parent or legal guardian, as Wespath deems appropriate.

***WHAT IS A QUALIFIED MEDICAL CHILD SUPPORT ORDER?***

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or to an administrative process, which provides for child support health benefit coverage and relates to benefits under the Plan and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which you, as a Participant, are eligible;
- the order specifies your name and last known address and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice, it meets the requirements above.

The QMCSO may not require the Plan to provide any type or form of benefit or option not otherwise provided under the Plan.





## MEDICAL AND BEHAVIORAL HEALTH BENEFITS INFORMATION

### Obtaining Your Medical and Behavioral Health Benefits

The Plan has selected Blue Cross and Blue Shield of Illinois as the Claims Administrator of its medical and behavioral health benefits for first-level claims. 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 or visiting **BenefitsAccess.org**, clicking the **Health** details tab, and following the link under the **Medical & Behavioral Health** section to your Claims Administrator's website.

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 are unavailable from an In-Network Provider within 50 miles, 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. This is called "balance billing." Federal law prohibits providers from balance billing you for certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. For more information



about these protections, please refer to the Plan's notice regarding "[Your Rights and Protection Against Surprise Medical Bills](#)."

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

#### **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.

#### **LIFETIME MAXIMUM BENEFIT**

There is no lifetime dollar limit applied to eligible Benefits payable under the 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. HealthFlex Out-of-Pocket Maximums also include Covered Pharmacy Expenses.

#### **MEDICALLY NECESSARY DETERMINATIONS**

The Claims Administrator of the benefit options under which you make your Claim will make the decision as to whether any health care services or supplies are medically necessary or medically appropriate. The Plan will not pay Claims that its Claims Administrators determine are not medically necessary or medically appropriate. Claims Administrators use evidence-based guidelines reviewed by physicians to determine medical necessity to maximize safety, efficiency, and effectiveness of covered health care services." Under the terms of its agreements with its Claims Administrators, and its authority under the Plan to delegate duties, **Wespath does not have the discretion or authority to make determinations of medical necessity.**

**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. If you have coverage under another plan, please see the section on *Coordination of Benefits*, as it may impact how much the Plan pays.

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

**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.

The Out-of-Pocket Maximum also includes Covered Pharmacy Expenses.

**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.

The Out-of-Pocket Maximum also includes Covered Pharmacy Expenses.

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.

## H2000, H2500 AND H5000—THE SCHEDULES

### General Overview

The H2000, H2500, and H5000 are HSA plans. An HSA plan is an IRS qualified high-deductible health plan that allows you to use a health savings account (HSA), explained below, to pay certain health care expenses directly. Most services, except preventive care, require the deductible to be met before the Plan pays its portion.

A health savings account (HSA) is used to offset eligible unreimbursed expenses incurred by the participant or eligible dependents. The H2000 and H2500 plans include HSA funding with plan enrollment. Depending on the Premium Credit set by the Plan Sponsor and the Required Contributions for selected Benefit Options, there may be excess Premium Credit deposited into an HSA. 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. HSA eligibility, contribution limits and use of the HSA are governed by the Internal Revenue Code. There is also an annual contribution limit applicable to HSAs set by the IRS.

This Schedule provides medical, behavioral health and prescription drug benefit highlights and a basic description of how these Plans work for you and your Dependents. You will be required to pay a portion of the Charges for most Covered Services whether those services were rendered by Network or Out-of-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You can obtain the names of Network Providers in your area by logging into [BenefitsAccess.org](https://BenefitsAccess.org), choosing the **Health** menu, and then following the prompts to your medical/behavioral health Claims Administrator or by calling the toll-free number shown on the back of your ID Card.

Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

H2000			H2500			H5000		
Deductibles	In-Network	Out-of-Network <sup>2</sup>	Deductibles	In-Network	Out-of-Network <sup>2</sup>	Deductibles	In-Network	Out-of-Network <sup>2</sup>
Individual	\$2,000 per Calendar Year	\$4,000 per Calendar Year	Individual	\$2,500 per Calendar Year	\$5,000 per Calendar Year	Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$4,000 per Calendar Year	\$8,000 per Calendar Year	Family	\$5,000 per Calendar Year	\$10,000 per Calendar Year	Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year
Deductible if Health Check Requirement not met <sup>1</sup>	\$2,250 per individual \$4,500 per family	\$4,250 per person \$8,500 per family	Deductible if Health Check Requirement not met <sup>1</sup>	\$2,750 per person \$5,500 per family	\$5,250 per person \$10,500 per family	Deductible if Health Check Requirement not met <sup>1</sup>	\$5,250 per individual \$10,500 per family	\$10,250 per person \$20,500 per family

<sup>1</sup>If the HealthCheck requirement is not satisfied, the deductible will be increased by for \$250 per individual or \$500 per family. Households with coverage in the H5000 plan who do not complete the Health Check will have their deductible *and* individual out-of-pocket maximum increased so the deductible and out-of-pocket max are the same amounts.

Eligible out-of-pocket expenses for the medical, behavioral health and prescription drug plans count toward one, *shared* Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the same for all plans.

Out-of-Pocket Maximum	H2000 and H2500 In-Network	H2000 and H2500 Out-of-Network <sup>2</sup>	H5000 In-Network	H5000 Out-of-Network <sup>2</sup>
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year	\$10,000 per Calendar Year	\$20,000 per Calendar Year
OOP Maximum if Health Check Requirement not met <sup>1</sup>	Same	Same	\$5,250 per Individual  Family OOP Max: \$10,500	\$10,250 per Individual  Family OOP Max: \$20,500
Lifetime Benefit Maximum: None				

<sup>2</sup>Reasonable charges for services provided by Out-of-Network providers will be based on the Medicare Fee Schedule applicable to the region in which the service is performed. Balance billing may occur.

#### Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums

Charges incurred for Covered Services from either Network or Out-of-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Out-of-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 Out-of-Network Providers will be used to satisfy the remainder of the Out-of-Network Provider Deductible and Out-of-Pocket Maximum.

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

**Health/Reimbursement Account Eligibility:** HSA, limited-purpose HRA, limited-purpose health care FSA, dependent care FSA.

#### Health Savings Account Funding Included with the Plan Election

Included Health Savings Account Contribution	H2000	H2500	H5000
Individual Coverage	\$1,000 per Calendar Year	\$250 per Calendar Year	None
2+ People Covered	\$2,000 per Calendar Year	\$500 per Calendar Year	None

## Plan Pays:

The percentages listed below reflect the percentage of Eligible Expenses.

Plan Benefits	H2000		H2500		H5000	
	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Physician Services</b> Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Specialist Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Surgery performed in the Physician's Office	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Well Child Care</b> (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 separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 60% for all services  (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 50% for all services  (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 100% after deductible for all services  (office visits, exams and tests) up to reasonable and customary amount.

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Well Adult Care</b> (age 16 and over)  One well person exam annually, including charges for an office visit, breast cancer screening, pap smear, prostate exam, routine blood work and colorectal cancer screening	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 60% for all services  (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 50% for all services  (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 100% for all services after deductible  (office visits, exams and tests) up to reasonable and customary amount.
Colonoscopy (colorectal cancer screening)	Plan pays 100%	Plan pays 60% up to the reasonable and customary amount. Not subject to Deductible	Plan pays 100%	Plan pays 50% up to the reasonable and customary amount. Not subject to Deductible	Plan pays 100%	Plan pays 100% up to the reasonable and customary amount after deductible.
<b>Pre-Admission Testing</b>  Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Specialist Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Outpatient facility	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Independent Lab and X-Ray Facility	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible



	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Inpatient Hospital Facility Services</b>	Plan pays 80% after Deductible	\$200 Copayment per admission then the Plan pays 60% after Deductible	Plan pays 70% after Deductible	\$200 Copayment per admission then the Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after 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	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	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	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	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	Limited to the Hospital's negotiated rate	Limited to the Hospital's most common daily rate for an ICU/CCU room	Limited to the Hospital's negotiated rate	Limited to the Hospital's most common daily rate for an ICU/CCU room

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Outpatient Hospital Facility Services</b> Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Inpatient Hospital Doctor's Visits/Consultations</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Inpatient Hospital Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Outpatient Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Second Opinions</b> Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Specialist Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Emergency and Urgent Care Services</b> Primary Care Physician Office Visit  Specialist Office Visit  Hospital Emergency Room  Urgent Care Facility or Outpatient Facility  Ambulance <i>To be covered, these services must be rendered as a result of a true emergency as defined in the Plan.</i>	Plan pays 80% after Deductible  Plan pays 80% after Deductible  Plan pays 80% after Deductible  Plan pays 80% after Deductible  Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*  Plan pays 80% after In-Network Deductible*  Plan pays 80% after In-Network Deductible*  Plan pays 80% after In-Network Deductible*  Plan pays 80% after In-Network Deductible*  <i>* If not a true emergency, as defined in the Plan, the Plan pays 60% after the Out of Network Deductible.</i>	Plan pays 70% after Deductible  Plan pays 70% after Deductible  Plan pays 70% after Deductible  Plan pays 50% after Deductible  Plan pays 50% after Deductible	Plan pays 70% after In-Network Deductible*  Plan pays 70% after In-Network Deductible*  Plan pays 70% after In-Network Deductible*  Plan pays 70% after In-Network Deductible*  Plan pays 70% after In-Network Deductible*  <i>* If not a true emergency, as defined in the Plan, the Plan pays 50% after the Out of Network Deductible.</i>	Plan pays 100% after Deductible  Plan pays 100% after Deductible  Plan pays 100% after Deductible  Plan pays 100% after Deductible  Plan pays 100% after Deductible	Plan pays 100% after In-Network Deductible*  Plan pays 100% after In-Network Deductible*  Plan pays 100% after In-Network Deductible*  Plan pays 100% after In-Network Deductible*  Plan pays 100% after In-Network Deductible*  <i>* If not a true emergency, as defined in the Plan, the Plan pays 100% after the Out of Network Deductible.</i>
<b>Inpatient Services at Other Health Care Facilities</b> (e.g., Skilled Nursing Facility, Rehabilitation Facility and Sub-Acute facilities)  <b>Calendar Year Maximum: 120 visit limit per level of care</b>	Plan pays 80% after Deductible	\$200 Copayment per admission then the Plan pays 60% after Deductible	Plan pays 70% after Deductible	\$200 Copayment per admission then the Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Laboratory and Radiology Services</b> MRIs, MRAs, CAT and PET Scans  Other Laboratory and Radiology Services  <i>All charges billed by an independent facility</i>	Plan pays 80% after Deductible  Plan pays 80% after Deductible	Plan pays 60% after Deductible  Plan pays 60% after Deductible	Plan pays 70% after Deductible  Plan pays 70% after Deductible	Plan pays 50% after Deductible  Plan pays 50% after Deductible	Plan pays 100% after Deductible  Plan pays 100% after Deductible	Plan pays 100% after Deductible  Plan pays 100% after Deductible
<b>Home Health Care</b>  <b>Calendar Year Maximum: 60 days</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Private Duty Nursing</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Hospice Care</b>  Inpatient Facility  Outpatient Facility  Hospice Room and Board	Plan pays 80% after Deductible  Plan pays 80% after Deductible  Limited to the hospice facility's negotiated rate	\$200 Copayment per admission then the Plan pays 60% after Deductible  Plan pays 60% after Deductible  Limited to the hospice facility's most common daily rate for a semi-private room	Plan pays 70% after Deductible  Plan pays 70% after Deductible  Limited to the hospice facility's negotiated rate	\$200 Copayment per admission then the Plan pays 50% after Deductible  Plan pays 50% after Deductible  Limited to the hospice facility's most common daily rate for a semi-private room	Plan pays 100% after Deductible  Plan pays 100% after Deductible  Limited to the hospice facility's negotiated rate	Plan pays 100% after Deductible  Plan pays 100% after Deductible  Limited to the hospice facility's most common daily rate for a semi-private room

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Bereavement Counseling</b> Inpatient Facility	Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program	\$200 copayment per admission then Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 70% after Deductible for Services provided as part of the Hospice Care Program	\$200 copayment per admission then Plan pays 50% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 100% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 100% after Deductible for Services provided as part of the Hospice Care Program
	Outpatient Services Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 70% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 50% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 100% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 100% after Deductible for Services provided as part of the Hospice Care Program
<b>Outpatient Short-Term Rehabilitative Therapy, includes:</b>						
Physical Therapy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Occupational Therapy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Speech Therapy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Alternative Therapy, includes:</b>						
Chiropractic Care	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Naprapathy	Plan pays 50% of contracted amount, after Deductible	Plan pays 50% of billed charges, after In-Network Deductible	Plan pays 50% of contracted amount, after Deductible	Plan pays 50% of billed charges, after In-Network Deductible	Plan pays 100% of billed charges, after Deductible	Plan pays 100% of billed charges, after In-Network Deductible
Acupuncture	Plan pays 50% of contracted amount, after Deductible	Plan pays 50% billed charges, after In-Network Deductible	Plan pays 50% of contracted amount, after Deductible	Plan pays 50% billed charges, after In-Network Deductible	Plan pays 100% of contracted amount, after Deductible	Plan pays 100% billed charges, after In-Network Deductible
Massage Therapy	Plan pays 50% of billed charges, after Deductible	Plan pays 50% of billed charges after In-Network Deductible	Plan pays 50% of billed charges, after Deductible	Plan pays 50% of billed charges after In-Network Deductible	Plan pays 100% of billed charges, after Deductible	Plan pays 100% of billed charges, after In-Network Deductible
<i>Coverage for chiropractic, naprapathy, acupuncture and massage therapy are <b>limited to 35 combined visits per calendar year.</b></i>						

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Maternity</b>						
Initial visit to confirm pregnancy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Physician's Charges for prenatal visits, postnatal visits, and delivery	Plan pays 100% for prenatal care (except for ultrasounds)	Plan pays 60% after Deductible	Plan pays 100% for prenatal care (except for ultrasounds)	Plan pays 50% after Deductible	Plan pays 100% for prenatal care (except for ultrasounds)	Plan pays 100% after Deductible
Ultrasounds and postnatal care	Plan pays 80% after Deductible for ultrasounds and subsequent eligible physician charges	Plan pays 60% after Deductible	70% Coinsurance after Deductible for ultrasounds and subsequent eligible physician charges	Plan pays 50% after Deductible	100% Coinsurance after Deductible for ultrasounds and subsequent eligible physician charges	Plan pays 100% after 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	Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn unless re-admitted)	Same as Plan's Inpatient Hospital facility benefit



	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Pregnancy Termination</b> (Medically necessary procedures only)						
<b>Inpatient Facility</b>	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit
<b>Outpatient Facility</b>	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
<b>Physician's Services</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 20% after Deductible
<b>Family Planning Office visits including tests and counseling</b>						
<b>Primary Care Physician</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Specialist Physician</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Outpatient Contraceptives Services</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Surgical Sterilization Procedures for Vasectomy</b> (excluding reversals)						
<b>Inpatient Facility</b>	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit
<b>Outpatient Facility</b>	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
<b>Physician's Services</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Infertility Treatment</b> (Office visit includes tests and counseling)						
Primary Care Physician	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Specialist Physician	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after 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	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
Physician's Services	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Maximum of 4 Assisted Reproductive Technologies (ART) cycles during lifetime.</b>						

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider*	Out-of-Network Provider <sup>2</sup>	In-Network Provider*	Out-of-Network Provider <sup>2</sup>	In-Network Provider*	Out-of-Network Provider <sup>2</sup>
<b>Organ Transplants</b> (Includes all medically appropriate non-experimental transplants)						
Transplant Center facility	Plan pays 80% after Deductible	Not covered	Plan pays 70% after Deductible	Not covered	Plan pays 100% after Deductible	Not covered
Transplant Center Physician	Plan pays 80% after Deductible	Not covered	Plan pays 70% after Deductible	Not covered	Plan pays 100% after Deductible	Not covered
Travel Services maximum	\$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered	\$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered	\$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered
*No coverage for transplants at a facility which is not a Blue Distinction Center.						
<b>Durable Medical Equipment</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>External Prosthetic Appliances</b>  <i>This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.</i>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
<b>Hearing Benefits</b> Hearing exam and evaluation  Hearing aid (not bone anchored)  <i>Excludes replacement and repair to hearing aids</i>	Plan pays 80% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible	Plan pays 60% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible	Plan pays 70% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible	Plan pays 50% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible	Plan pays 100% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible	Plan pays 100% after Deductible  Plan pays 50% up to \$3,000 every 24 months, after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Medically Necessary Dental Care</b> Physician's Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Inpatient Facility	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
Physician Services  <i>Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth</i>	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible	Plan pays 70% after the Deductible	Plan pays 50% after the Deductible	Plan pays 100% after the Deductible	Plan pays 100% after the Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Temporomandibular Joint Disorder</b> (Surgical and Non-Surgical Treatment)						
Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Inpatient Facility	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
Physician Services	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 70% after Deductible	Plan pays 50% after Deductible	Plan pays 100% after Deductible	Plan pays 100% after Deductible

	H2000		H2500		H5000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Mental Health Office Visits</b> Psychiatrist, Psychologist, other mental health professionals	Plan pays 80%, after deductible	Plan pays 80% of billed charges, after In Network deductible	Plan pays 70%, after deductible	Plan pays 70% of billed charges, after In Network deductible	Plan pays 100%, after deductible	Plan pays 100% of billed charges, after In Network deductible
<b>Mental Health Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible	Plan pays 70% after deductible	\$200 copayment per admission then Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible
<b>Substance Abuse Outpatient Office Visits</b>	Plan pays 80%, after deductible	Plan pays 80% of billed charges, after In Network deductible	Plan pays 70%, after deductible	Plan pays 50% of billed charges, after In Network deductible	Plan pays 100%, after deductible	Plan pays 100% of billed charges, after In Network deductible
<b>Substance Abuse Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible	Plan pays 70% after deductible	\$200 copayment per admission then Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible
<b>Other Mental Health and Substance Abuse Outpatient Services</b>	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible

**Special rules for certain out-of-network providers:** As required by applicable law, in-network cost sharing rules may apply to determine your coinsurance for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this chart. Your coinsurance amount will be determined based on the applicable “qualifying payment amount” (QPA), which is the median of the Claim Administrator’s in-network rates for the applicable service and geographic region. The providers are prohibited from balance billing you for more than your coinsurance based on the QPA. For more information, please contact the Claims Administrator.



## C2000 AND C3000—THE SCHEDULES

The C2000 and C3000 are HRA plans. An HRA plan allows you to use a health reimbursement account (HRA), explained below, to pay certain health care expenses directly. Most services, except preventive care, pharmacy and behavioral health, require the deductible to be met before the Plan pays its portion.

A health reimbursement arrangement (HRA, also called a health reimbursement account) is funded by the Plan or employer and is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. Both the C2000 and C3000 include HRA funding with enrollment. Depending on the Premium Credit set by the Plan Sponsor and the Required Contributions for selected Benefit Options, there may be excess Premium Credit deposited into an HRA as well. Participants may not contribute to an HRA. 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 as long as the individual is eligible for the HRA. Details about eligibility for the HRA can be found in this booklet in the section on Reimbursement Accounts.

This Schedule provides medical, behavioral health and prescription drug benefit highlights and a basic description of how these Plans work for you and your Dependents. You will be required to pay a portion of the Charges for most Covered Services whether those services were rendered by Network or Out-of-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You can obtain the names of Network Providers in your area by logging into [BenefitsAccess.org](https://BenefitsAccess.org), choosing the **Health** menu, and then following the prompts to your medical/behavioral health Claims Administrator or by calling the toll-free number shown on the back of your ID Card.

Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance. Co-payments do not count toward the Deductible.

C2000			C3000		
Deductibles	In-Network	Out-of-Network <sup>2</sup>	Deductibles	In-Network	Out-of-Network <sup>2</sup>
Individual	\$2,000 per Calendar Year	\$4,000 per Calendar Year	Individual	\$3,000 per Calendar Year	\$6,000 per Calendar Year
Family	\$4,000 per Calendar Year	\$8,000 per Calendar Year	Family	\$6,000 per Calendar Year	\$12,000 per Calendar Year
Deductible if Health Check Requirement not met <sup>1</sup>	\$2,250 per individual \$4,500 per family	\$4,250 per person \$8,500 per family	Deductible if Health Check Requirement not met <sup>1</sup>	\$3,250 per individual \$6,500 per family	\$6,250 per person \$12,500 per family

<sup>1</sup> If the HealthCheck requirement is not satisfied, the deductible will be increased by for \$250 per individual or \$500 per family.

Eligible out-of-pocket expenses for the medical, behavioral health and prescription drug plans count toward one, *shared* Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the same for both the C2000 and C3000 plans.

Out-of-Pocket Maximum	In-Network	Out-of-Network <sup>2</sup>
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year
Lifetime Benefit Maximum: None		

<sup>2</sup> Reasonable charges for services provided by Out-of-Network providers will be based on the Medicare Fee Schedule applicable to the region in which the service is performed. This fee is considered reasonable, and the maximum payment allowed for the service. Balance billing may occur.

**Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums**

Charges incurred for Covered Services from either Network or Out-of-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Out-of-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 Out-of-Network Providers will be used to satisfy the remainder of the Out-of-Network Provider Deductible and Out-of-Pocket Maximum.

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

**Health/Reimbursement Account Eligibility:** HRA (included), full-use health care FSA, dependent care FSA.

**Health Reimbursement Account Funding Included with the Plan Election**

Included Health Reimbursement Account Contribution	C2000	C3000
Individual Coverage	\$1,000 per Calendar Year	\$250 per Calendar Year
2+ People Covered	\$2,000 per Calendar Year	\$500 per Calendar Year

**Plan Pays:**

The percentages listed below reflect the percentage of Eligible Expenses.

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Physician Services</b> Primary Care Physician Office Visit  Specialist Physician Office Visit  Surgery performed in the Physician's Office	Plan pays 80% after Deductible  Plan pays 80% after Deductible  Plan pays 80% after Deductible	Plan pays 60% after Deductible  Plan pays 60% after Deductible  Plan pays 60% after Deductible	Plan pays 50% after Deductible  Plan pays 50% after Deductible  Plan pays 50% after Deductible	Plan pays 30% after Deductible  Plan pays 30% after Deductible  Plan pays 30% after Deductible
<b>Well Child Care</b> (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 separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 60% for all services (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 30% for all services (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible
<b>Well Adult Care</b> (age 16 and over)  One well person exam annually, including charges for an office visit, breast cancer screening, pap smear, prostate exam, routine blood work and colorectal cancer screening  Colonoscopy (colorectal cancer screening)	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately 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% for all services (office visits, exams and tests) up to reasonable and customary amount. Not subject to Deductible  Plan pays 60% up to the reasonable and customary amount. Not subject to Deductible	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately 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. Not subject to Deductible  Plan pays 30% up to the reasonable and customary amount. Not subject to Deductible

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Pre-Admission Testing</b>				
Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Specialist Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Outpatient facility	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Independent Lab and X-Ray Facility	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Inpatient Hospital Facility Services</b>	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after Deductible	Plan pays 50% after Deductible	\$200 Co-payment per admission then the Plan pays 30% after 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	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	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	Limited to the Hospital's negotiated rate	Limited to the Hospital's most common daily rate for an ICU/CCU room
<b>Outpatient Hospital Facility Services</b>				
Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Inpatient Hospital Doctor's Visits/Consultations</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Inpatient Hospital Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Outpatient Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Second Opinions</b> Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Specialist Physician Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Emergency and Urgent Care Services</b> Primary Care Physician Office Visit	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*	Plan pays 50% after Deductible	Plan pays 50% after In-Network Deductible*
Specialist Office Visit	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*	Plan pays 50% after Deductible	Plan pays 50% after In-Network Deductible*
Hospital Emergency Room	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*	Plan pays 50% after Deductible	Plan pays 50% after In-Network Deductible*
Urgent Care Facility or Outpatient Facility	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*	Plan pays 50% after Deductible	Plan pays 50% after In-Network Deductible*
Ambulance  <i>To be covered, these services must be rendered as a result of a true emergency as defined in the Plan.</i>	Plan pays 80% after Deductible	Plan pays 80% after In-Network Deductible*  <i>* If not a true emergency, as defined in the Plan, the Plan pays 60% after the Out of Network Deductible.</i>	Plan pays 50% after Deductible	Plan pays 50% after In-Network Deductible*  <i>* If not a true emergency, as defined in the Plan, the Plan pays 30% after the Out of Network Deductible.</i>

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Inpatient Services at Other Health Care Facilities</b> (e.g., Skilled Nursing Facility, Rehabilitation Facility and Sub-Acute facilities)  <b>Calendar Year</b> <b>Maximum: 120 visit limit per level of care</b>	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after Deductible	Plan pays 50% after Deductible	\$200 Co-payment per admission then the Plan pays 30% after Deductible
<b>Laboratory and Radiology Services</b> MRIs, MRAs, CAT and PET Scans  Other Laboratory and Radiology Services  <i>All charges billed by an independent facility</i>	Plan pays 80% after Deductible  Plan pays 80% after Deductible	Plan pays 60% after Deductible  Plan pays 60% after Deductible	Plan pays 50% after Deductible  Plan pays 50% after Deductible	Plan pays 30% after Deductible  Plan pays 30% after Deductible
<b>Home Health Care</b>  <b>Calendar Year</b> <b>Maximum: 60 days</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Private Duty Nursing</b>	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Hospice Care</b>  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 Deductible  Plan pays 60% after the Deductible  Limited to the hospice facility's most common daily rate for a semi-private room	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 Deductible  Plan pays 30% after the Deductible  Limited to the hospice facility's most common daily rate for a semi-private room

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Bereavement Counseling</b>				
Inpatient Facility	Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program	\$200 copayment per admission then Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 50% after Deductible for Services provided as part of the Hospice Care Program	\$200 copayment per admission then Plan pays 30% after Deductible for Services provided as part of the Hospice Care Program
Outpatient Services	Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 50% after Deductible for Services provided as part of the Hospice Care Program	Plan pays 30% after Deductible for Services provided as part of the Hospice Care Program
<b>Outpatient Short-Term Rehabilitative Therapy</b> , includes:				
Physical Therapy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Occupational Therapy	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Speech Therapy	Plan pays 80% after Deductible	Plan pays 60% after the Deductible	Plan pays 50% after Deductible	Plan pays 30% after the Deductible



	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Alternative Therapy, includes:</b>  Chiropractic Care  Naprapathy  Acupuncture  Massage Therapy  <i>Coverage for chiropractic, naprapathy, acupuncture and massage therapy is limited to 35 combined visits per calendar year.</i>	Plan pays 80% after Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible	Plan pays 60% after Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible	Plan pays 50% after Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible	Plan pays 30% after Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible
<b>Maternity</b>  Initial visit to confirm pregnancy  Physician's Charges for prenatal visits, postnatal visits, and delivery  Ultrasounds and postnatal care  Facility Charges (Inpatient Hospital, birthing center)	Plan pays 80% after Deductible  Plan pays 100% for prenatal care (except for ultrasounds)  Plan pays 80% 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 60% after Deductible  Plan pays 60% after Deductible  Plan pays 60% after Deductible  Same as Plan's Inpatient Hospital facility benefit	Plan pays 50% after Deductible  Plan pays 100% for prenatal care (except for ultrasounds)  Plan pays 50% 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 30% after Deductible  Plan pays 30% after Deductible  Plan pays 30% after Deductible  Same as Plan's Inpatient Hospital facility benefit

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Pregnancy Termination</b> (Medically necessary procedures only)				
Inpatient Facility	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	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 Deductible	Plan pays 50% after the Deductible	Plan pays 30% after Deductible
<b>Family Planning</b> Office visits including tests and counseling				
Primary Care Physician	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Specialist Physician	Plan pays 80% after Deductible	Plan pays 60% after the Deductible	Plan pays 50% after Deductible	Plan pays 30% after the Deductible
Outpatient Contraceptives Services	Plan pays 80% after Deductible	Plan pays 60% after the Deductible	Plan pays 50% after Deductible	Plan pays 30% after the Deductible
<b>Surgical Sterilization Procedures for Vasectomy</b> (excluding reversals)				
Inpatient Facility	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
Physician's Services	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible

	C2000		C3000	
Plan Benefits	In-Network Provider*	Out-of-Network Provider <sup>2</sup>	In-Network Provider*	Out-of-Network Provider <sup>2</sup>
<b>Infertility Treatment</b> (Office visit includes tests and counseling) Primary Care Physician  Specialist Physician  Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)  Inpatient Facility  Outpatient Facility  Physician's Services  <i>Maximum of 4 Assisted Reproductive Technologies (ART) cycles during lifetime.</i>	Plan pays 80% after Deductible  Plan pays 80% after Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 80% after Deductible	Plan pays 60% after Deductible  Plan pays 60% after Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 60% after Deductible	Plan pays 50% after Deductible  Plan pays 50% after Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 50% after Deductible	Plan pays 30% after Deductible  Plan pays 30% after Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 30% after Deductible
<b>Organ Transplants</b> (Includes all medically appropriate non-experimental transplants)  Transplant Center facility  Transplant Center Physician  Travel Services maximum  *No coverage for transplants at a facility which is not a Blue Distinction Center.	Plan pays 80% after Deductible  Plan pays 80% after Deductible  \$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered  Not covered  Not covered	Plan pays 50% after Deductible  Plan pays 50% after Deductible  \$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered  Not covered  Not covered

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Durable Medical Equipment</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>External Prosthetic Appliances</b>  <i>This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.</i>	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Hearing Benefits</b> Hearing exam and evaluation  Hearing aid (not bone anchored)  <i>Excludes replacement and repair to hearing aids</i>	Plan pays 80% after Deductible  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible	Plan pays 60% after Deductible  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible	Plan pays 50% after Deductible  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible	Plan pays 30% after Deductible  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible
<b>Medically Necessary Dental Care</b> Physician's Office Visit  Inpatient Facility  Outpatient Facility  Physician Services  <i>Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth</i>	Plan pays 80% after 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 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 50% after 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 Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 30% after the Deductible

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Temporomandibular Joint Disorder</b> (Surgical and Non-Surgical Treatment)				
Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
Inpatient Facility	Same as Plan's Inpatient Hospital facility benefit	Same as Plan's Inpatient Hospital facility benefit	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	Same as Plan's Outpatient Hospital facility benefit	Same as Plan's Outpatient Hospital facility benefit
Physician Services	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible
<b>Licensed Dietitian</b>				
Office Visit	Plan pays 80% after Deductible	Plan pays 60% after Deductible	Plan pays 50% after Deductible	Plan pays 30% after Deductible

	C2000		C3000	
Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Mental Health Office Visits</b> Psychiatrist, Psychologist, other mental health professionals	Plan pays 80%, not subject to deductible	Plan pays 80% of billed charges, not subject to deductible	Plan pays 50%, not subject to deductible	Plan pays 50% of billed charges, not subject to deductible
<b>Mental Health Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible	Plan pays 50% after deductible	\$200 copayment per admission then Plan pays 30% after deductible
<b>Substance Abuse Outpatient Office Visits</b>	Plan pays 80%, not subject to deductible	Plan pays 80% of billed charges, not subject to deductible	Plan pays 50%, not subject to deductible	Plan pays 50% of billed charges, not subject to deductible
<b>Substance Abuse Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible	Plan pays 50% after deductible	\$200 copayment per admission then Plan pays 30% after deductible
<b>Other Mental Health and Substance Abuse Outpatient Services</b>	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 30% after deductible

**Special rules for certain out-of-network providers:** As required by applicable law, in-network cost sharing rules may apply to determine your coinsurance for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this chart. Your coinsurance amount will be determined based on the applicable “qualifying payment amount” (QPA), which is the median of the Claim Administrator’s in-network rates for the applicable service and geographic region. The providers are prohibited from balance billing you for more than your coinsurance based on the QPA. For more information, please contact the Claims Administrator.

## B1000—THE SCHEDULES

The B1000 is a PPO plan.

This Schedule provides medical, behavioral health and prescription drug benefit highlights and a basic description of how this Plan works for you and your Dependents. You will be required to pay a portion of the Charges for most Covered Services whether those services were rendered by Network or Out-of-Network Providers. The portion you pay is the Co-payment, Deductible or Co-insurance. You can obtain the names of Network Providers in your area by logging into [BenefitsAccess.org](https://BenefitsAccess.org), choosing the **Health** menu, and then following the prompts to your medical/behavioral health Claims Administrator or by calling the toll-free number shown on the back of your ID Card.

Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance. Co-payments do not count toward the deductible.

Deductibles	In-Network	Out-of-Network <sup>2</sup>
Individual	\$1,000 per Calendar Year	\$2,000 per Calendar Year
Family	\$2,000 per Calendar Year	\$4,000 per Calendar Year
Deductible if Health Check Requirement not met <sup>1</sup>	\$1,250 per individual \$2,500 per family	\$2,250 per person \$4,500 per family

<sup>1</sup>If the HealthCheck requirement is not satisfied, the deductible will be increased by for \$250 per individual or \$500 per family.

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

Out-of-Pocket Maximum	In-Network	Out-of-Network <sup>2</sup>
Individual	\$5,000 per Calendar Year	\$10,000 per Calendar Year
Family	\$10,000 per Calendar Year	\$20,000 per Calendar Year
Lifetime Benefit Maximum: None		

<sup>2</sup>Reasonable charges for services provided by Out-of-Network providers will be based on the Medicare Fee Schedule applicable to the region in which the service is performed. Balance billing may occur.

**Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums**

Charges incurred for Covered Services from either Network or Out-of-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Out-of-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 Out-of-Network Providers will be used to satisfy the remainder of the Out-of-Network Provider Deductible and Out-of-Pocket Maximum.

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

**Health/Reimbursement Account Eligibility:** Full-use health care FSA, dependent care FSA. Excess premium credit, if applicable, is deposited to HRA. No funding is included with the Plan Election.



## Plan Pays:

The percentages listed below reflect the percentage of Eligible Expenses.

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Physician Services</b>  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
<b>Well Child Care</b> (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 separately as long as these services were rendered in the office of a network provider as part of the wellness exam.	Plan pays 100% for all services (office visits, exams and tests) up to reasonable and customary amount.
<b>Well Adult Care</b> (age 16 and over)  One well person exam annually, including charges for an office visit, breast cancer screening, pap smear, prostate exam, routine blood work and colorectal cancer screening  Colonoscopy (colorectal cancer screening)	Plan pays 100%  Plan pays 100% for X-ray/Lab services billed separately 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 100% for all services (office visits, exams and tests) up to reasonable and customary amount  Plan pays 60% up to the reasonable and customary amount. Not subject to deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Pre-Admission Testing</b>		
Primary Care Physician Office Visit	Plan pays 100% after \$30 Co-payment	Plan pays 60% after the Deductible
Specialist Physician Office Visit	Plan pays 100% after \$50 Co-payment	Plan pays 60% after the Deductible
Outpatient facility	Plan pays 80% after Deductible	Plan pays 60% after the Deductible
Independent Lab and X-Ray Facility	Plan pays 80% after Deductible	Plan pays 60% after the Deductible
<b>Inpatient Hospital Facility Services</b>	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after 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
<b>Outpatient Hospital Facility Services</b>		
Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 80% after Deductible	Plan pays 60% after Deductible
<b>Inpatient Hospital Doctor's Visits/Consultations</b>	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after Deductible
<b>Inpatient Hospital Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after Deductible
<b>Outpatient Professional Services</b> (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after Deductible	Plan pays 60% after Deductible
<b>Second Opinions</b>		
Primary Care Physician Office Visit	Plan pays 100% after a \$30 Co-payment	Plan pays 60% after Deductible
Specialist Physician Office Visit	Plan pays 100% after a \$50 Co-payment	Plan pays 60% after Deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Emergency and Urgent Care Services</b> Primary Care Physician Office Visit  Specialist Office Visit  Hospital Emergency Room  Urgent Care Facility or Outpatient Facility  Ambulance  <i>To be covered, these services must be rendered as a result of a true emergency as defined in the Plan.</i>	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  <i>*Copayment waived if admitted</i> <i>**If not a true emergency, as defined in the Plan, the Plan pays 80% after the Deductible.</i>	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 In-Network Deductible  <i>* Copayment waived if admitted</i> <i>** If not a true emergency, as defined in the Plan, the Plan pays 60% after the Out of Network Deductible.</i>
<b>Inpatient Services at Other Health Care Facilities</b> (e.g., Skilled Nursing Facility, Rehabilitation Facility and Sub-Acute facilities)  <i>Calendar Year Maximum: 120 visit limit per level of care</i>	Plan pays 80% after Deductible	\$200 Co-payment per admission then the Plan pays 60% after Deductible
<b>Laboratory and Radiology Services</b> MRIs, MRAs, CAT and PET Scans  Other Laboratory and Radiology Services  <i>All charges billed by an independent facility</i>	Plan pays 80% after Deductible  Plan pays 80% after Deductible	Plan pays 60% after Deductible  Plan pays 60% after Deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Home Health Care</b>  <i>Calendar Year Maximum: 60 days</i>	Plan pays 80% after Deductible	Plan pays 60% after Deductible
<b>Private Duty Nursing</b>	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
<b>Hospice Care</b>  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 Deductible  Plan pays 60% after the Deductible  Limited to the hospice facility's most common daily rate for a semi-private room
<b>Bereavement Counseling</b>  Inpatient Facility  Outpatient Services	Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program  Plan pays 80% after Deductible for Services provided as part of the Hospice Care Program	\$200 Co-payment per admission then Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program  Plan pays 60% after Deductible for Services provided as part of the Hospice Care Program
<b>Outpatient Short-Term Rehabilitative Therapy, includes:</b>  Physical Therapy  Occupational Therapy  Speech Therapy	Plan pays 100% after a \$30 Co-payment  Plan pays 100% after a \$30 Co-payment  Plan pays 100% after a \$30 Co-payment	Plan pays 60% after Deductible  Plan pays 60% after Deductible  Plan pays 60% after the Deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Alternative Therapy</b> , includes:  Chiropractic Care  Naprapathy  Acupuncture  Massage Therapy  <i>Coverage for chiropractic, naprapathy, acupuncture and massage therapy is limited to 35 combined visits per calendar year.</i>	Plan pays 100% after a \$30 Co-payment  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible	Plan pays 60% after Deductible  Plan pays 50% of billed charges, not subject to Deductible  Plan pays 50% billed charges, not subject to Deductible  Plan pays 50% of billed charges, not subject to the Deductible
<b>Maternity</b>  Initial visit to confirm pregnancy  Physician's Charges for prenatal visits, postnatal visits, and delivery  Ultrasounds and postnatal care  Facility Charges (Inpatient Hospital, birthing center)	Plan pays 100% after a \$30 Co-payment  Plan pays 100% for prenatal care (except for ultrasounds)  Plan Pays 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 60% after Deductible  Plan pays 60% after Deductible  Plan pays 60% after Deductible  Same as Plan's Inpatient Hospital facility benefit
<b>Pregnancy Termination</b> (Medically necessary 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 Deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Family Planning</b> Office visits including tests and counseling  Primary Care Physician  Specialist Physician  Outpatient Contraceptives Services	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 Deductible  Plan pays 60% after the Deductible  Plan pays 60% after the Deductible
<b>Surgical Sterilization Procedures for Vasectomy</b> (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 Deductible	Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 60% after Deductible
<b>Infertility Treatment</b> (Office visit includes tests and counseling)  Primary Care Physician  Specialist Physician  Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)  Inpatient Facility  Outpatient Facility  Physician's Services  <i>Maximum of 4 Assisted Reproductive Technologies (ART) cycles during lifetime.</i>	Plan pays 100% after a \$30 Co-payment, per visit  Plan pays 100% after a \$50 Co-payment, per visit  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 80% after Deductible	Plan pays 60% 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 Deductible

Plan Benefits	In-Network Provider*	Out-of-Network Provider <sup>2</sup>
<b>Organ Transplants</b> (Includes all medically appropriate non-experimental transplants)  Transplant Center facility  Transplant Center Physician  Travel services maximum  *No coverage for transplants at a facility which is not a Blue Distinction Center.	Plan pays 80% after the Deductible  Plan pays 80% after the Deductible  \$10,000 per transplant; to include transportation, lodging and meals; any daily limitation is subject to IRS regulations	Not covered  Not covered  Not covered
<b>Durable Medical Equipment</b>	Plan pays 80% after Deductible	Plan pays 60% after Deductible
<b>External Prosthetic Appliances</b>  <i>This benefit includes coverage for Cranial prosthetics with a lifetime maximum of 5 wigs.</i>	Plan pays 80% after Deductible	Plan pays 60% after Deductible
<b>Hearing Benefits</b> Hearing exam and evaluation  Hearing aid (not bone anchored)  <i>Excludes replacement and repair to hearing aids</i>	Plan pays 100% after a \$50 Co-payment  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible	Plan pays 60% after Deductible  Plan pays 50% up to \$3,000 every 24 months, not subject to Deductible
<b>Medically Necessary Dental Care</b> Physician's Office Visit  Inpatient Facility  Outpatient Facility  Physician Services  <i>Limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth</i>	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 Deductible  Same as Plan's Inpatient Hospital facility benefit  Same as Plan's Outpatient Hospital facility benefit  Plan pays 60% after Deductible

Plan Benefits	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Temporomandibular Joint Disorder</b> (Surgical and Non-Surgical Treatment)		
Office Visit	Plan pays 100% after a \$50 Co-payment	Plan pays 60% after 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 Deductible	Plan pays 60% after Deductible
<b>Licensed Dietitian</b> Office Visit	Plan pays 100% after a \$30 Co-payment	Plan pays 60% after the Deductible
<b>Mental Health Office Visits</b> <i>Psychiatrist, Psychologist, other mental health professionals</i>	\$15 co-payment then plan pays 100%	\$15 co-payment then plan pays 100% of billed charges for office visits.
<b>Mental Health Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible
<b>Substance Abuse Outpatient Office Visits</b>	\$15 co-payment then plan pays 100% for office visits	\$15 co-payment then the plan pays 100% of billed charges for office visits.
<b>Substance Abuse Inpatient Services</b>	Plan pays 80% after deductible	\$200 copayment per admission then Plan pays 60% after deductible
<b>Other Mental Health and Substance Abuse Outpatient Services</b>	Plan pays 80% after deductible	Plan pays 60% after deductible

**Special rules for certain out-of-network providers:** As required by applicable law, in-network cost sharing rules may apply to determine your coinsurance for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this chart. Your coinsurance amount will be determined based on the applicable "qualifying payment amount" (QPA), which is the median of the Claim Administrator's in-network rates for the applicable service and geographic region. The providers are prohibited from balance billing you for more than your coinsurance based on the QPA. For more information, please contact the Claims Administrator.



#### **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 applicable Schedule. Only charges made by providers who are licensed and registered in the state in which they practice shall be considered Covered Services.

**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 in intentionally limited to specific coverage parameters.

Covered Services include:

- 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 by a Physician or a Psychologist for professional Services.
- Charges made by a Nurse for professional nursing service.
- Charges for annual breast screenings, including mammograms, breast MRIs and breast ultrasounds
- 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, including unplanned charges during a screening colonoscopy.
- Charges made for annual routine blood work.
- 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 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 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 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 licensed ambulance service to or from the nearest Hospital where the needed medical or behavioral health care and treatment can be provided in an Emergency.
- Transportation by regularly scheduled airline, railroad or air ambulance to the nearest medical or behavioral health facility qualified to give the required treatment.
- Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as determined appropriate) between facilities is a covered service when the transport is any of the following:
  - From a non-Participating Hospital to a Participating Hospital.
  - To a Hospital that provides a higher level of care that was not available at the original Hospital.
  - To a more cost-effective acute care facility.
    - From an acute facility to a sub-acute setting.
- 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 for Medically Necessary Prescription Drugs while an individual is confined in a Skilled Nursing Facility.
- Charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.
- 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 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, as well as treatment when related to an underlying medical condition or accident. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

- 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:
  - occurrence of sexual contact; 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 massage therapy, regardless of diagnosis.
- Charges for medical and surgical services intended primarily for the treatment or control of obesity, subject to the Claim Administrator's medical necessity requirements.
- Charges for telemedicine services provided by the HealthFlex preferred telemedicine provider (MD LIVE), limited to one visit per 24 hours per individual.
- Gender Reassignment 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. Coverage is limited to charges made for a continuous course of dental treatment started within 6 months of an Injury to sound, natural teeth.
  - Surgery benefits are limited to the following dental services: (1) Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, (2) Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and/or (3) 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.
  - respite care by an aide who is employed by the hospice for up to four (4) hours per day. (Respite care provides care of the covered person to allow temporary relief to family members or friends from the duties of caring for the covered person).

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 and associated procedures, shoe additions, 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 (IVF) and transfer procedures including low tubal ovum transfer (LTOF), gamete intrafallopian transfer (GIFT), embryo transfer (ET), and zygote intrafallopian transfer (ZIFT), 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 Assisted Reproductive Technology cycles, counted by a transfer procedure. If a live birth follows one of the transfer procedures, two additional Assisted Reproductive Technology cycles, counted by a transfer procedure, shall be covered, regardless of how many transfer procedures have already been completed. The maximum number of Assisted Reproductive Technology cycles is always counted by the number of transfer procedures. Once the maximum number of transfer procedures have been completed, there is no further coverage by the plan regardless of the number of other procedures that have been completed or whether additional embryos are viable.

In addition to the above provisions, IVF and 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 Infertility 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;
- Non-Medically Necessary Fetal reduction Surgery; and
- Health services associated with the use of non-surgical or drug-induced pregnancy termination, unless Medically Necessary.
- Cryopreservation or storage of mature gametes (oocytes or sperm) or embryos is only covered for individuals facing iatrogenic infertility due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease.

### 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. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

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, Otolologist, 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.

### **Benefit Period**

Your hearing care benefit is a one year period 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 Hearing Benefit 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 (may be covered through the standard medical benefit if Medically Necessary)

- Drugs or other medications (may be covered through the standard pharmacy benefit if Medically Necessary)
- 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.

### **ORGAN TRANSPLANTS**

Covered Services include your benefits for certain 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.

When an organ transplant is recommended by your Physician, you must contact the Care Coordinator by telephone before your transplant Surgery has been scheduled to ensure your transplant is scheduled at a Blue Distinction Center. Organ Transplants must be received at a Blue Distinction Center in order to have coverage. Other facilities that are not Blue Distinction Centers, even if in-network, are not eligible for covered transplant services.

If you are the recipient of the transplant, travel benefits up to \$10,000 per transplant will be provided for transportation, lodging and meals for you and a companion, subject to IRS rules. 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 travel benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

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.
- The orthognathic procedure is only covered if it's medically necessary and necessary for the success of another covered medically necessary procedure.

Repeat or subsequent Surgeries for the same condition are Covered Services only when there is the probability of significant additional improvement, as recommended by the Provider and determined by 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
- Breast screening services, including mammograms, breast MRIs, and breast ultrasounds as recommended by a provider.
- Breastfeeding support, supplies and counseling

#### **BENEFITS EXTENSION DURING HOSPITALIZATION**

*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 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.

#### **BEHAVIORAL HEALTH SERVICES**

##### ***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, including MDLIVE telehealth 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.
- 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
  - focused on treating 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.

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

### **General Limitations and Exclusions for Medical and Behavioral Health Benefits**

The Plan will not pay benefits for any of the services, treatments, items or supplies that are excluded from coverage under the Plan, even if either or both of the following is/are true:

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

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

- 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 that should be covered by the U.S. military or its designee.
- 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 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 or co-surgeon can only be a portion of the surgeon's allowable charge, as determined by the Claims Administrator. 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. Certain procedures are not eligible for separate reimbursement of assistant or co-surgeons, as determined by the Claims Administrator.
- 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. Other benefits may also be available under the Vision benefit.
- 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 in lieu of surgery.
- 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 Charges made by any Provider who is a member of your family or your Dependent's family or who has your same place of residence.
- 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, except emergency charges incurred while traveling out of the U.S.

- 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 who has Medicare paying primary, 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 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.
- 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.
- 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.
- 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.
- Services or supplies that do not meet accepted standards of medical, behavioral health, and/or dental practice.
- Long-term care service.
- Respite Care Service, except as specifically mentioned under the Hospice Program.
- Inpatient Private Duty Nursing Service.
- 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 or otherwise as defined by the Claims Administrator.
- Charges for failure to keep a scheduled visit or Charges for completion of a Claim Form.

- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Benefit Booklet.
- Blood derivatives that are not classified as drugs in the official formularies.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions, and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Benefits that are duplicated because the Spouse, parent and/or child are covered separately under this Plan.
- 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.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Benefit Booklet.
- Elective abortions.
- Replacement of external prostheses due to loss, theft or destruction; or expenses for any biomechanical external prosthetic devices.
- 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.
- Therapy or blood administration 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.
- Artificial aids including, but not limited to garter belts, corsets and dentures.
- Court-ordered treatment or Hospitalization unless such treatment is prescribed by a Physician and listed under the Covered Services section of this Benefit Booklet.
- Private Hospital rooms and/or Private Duty Nursing unless determined by the Claims Administrator to be Medically Necessary.
- 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 except medically necessary non-surgical treatment for weight loss that is administered and supervised by a physician. 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.
- 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.
- Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Claims Administrator for the purpose of making treatment decisions.



- 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.
- 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.
- 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.
- 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.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
- 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.
- 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.
- Travel or transportation expenses, even though prescribed by a Physician.
- 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.
- Rest cures.
- Psychosurgery.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring or associated appliances, except when provided as a part of treatment for documented obstructive sleep apnea.
- 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.
- Any Charge for services, supplies or equipment advertised by the Provider as free.
- Any Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
- Any Charges prohibited by federal anti-kickback or self-referral statutes.
- Chelation therapy, except to treat heavy metal poisoning.

- Any Charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
- Megavitamin and nutrition-based therapy.
- Except as described in Covered Services, nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Except as required by law, services performed by unlicensed Clinicians or which are outside the scope of a Clinician's licensure. This exclusion does not apply to Covered Behavioral Health Services performed by pastoral counselors.
- Behavioral health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- In the event an Out-of-Network Provider waives Co-payments, Co-insurance and/or any Deductible for a particular health service, no benefits are provided for the health service for which the Co-payments, Co-insurance and/or Deductible are waived.
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Herbal medicine, herbal drugs, holistic or homeopathic treatment, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation programs or lifestyle programs, including any services provided in conjunction with, or as a part of, such programs.

## **Quantum Health's Care Coordination Process – Medical Benefits**

### **INTRODUCTION**

This section describes the "Care Coordination" process by Quantum Health for medical benefits under the Plan. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Participants and Dependents, and coordinate activities and information flow between the providers.

Care Coordination is intended to help you obtain quality healthcare and services in the most appropriate setting and reduce unnecessary medical costs. The Care Coordinators are available to you and your providers for information, assistance, and guidance, and can be reached toll-free by calling:

**Care Coordinators: 1-833-762-0876**

**It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of Quantum Health.**

## CARE COORDINATION REQUIREMENTS

In order to receive the highest benefits available in the Plan, you must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network providers
- Designating a Coordinating Provider (PCP)
- The Care Coordination Process and Utilization Management
  - Preauthorization and Clinical Review
  - Concurrent Utilization Review
  - Personal Care Guide Management

### Use of In-Network Providers

The Plan offers a broad network of providers and provides the highest level of benefits when you utilize In-Network providers. These networks will be indicated on your insurance card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits.** Specific benefit levels are shown in the Schedule of Benefits.

### Designated Coordinating Provider

You are asked to designate a coordinating Primary Care Provider (PCP) for each covered member of your family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, you are encouraged to designate an In-Network Primary Care Provider (PCP) to be your coordinating Provider.** The Care Coordination process generally begins with the coordinating Provider who maintains a relationship with you, provides general healthcare evaluation, guidance, and management.

You are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide you as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

**Care Coordinators: 1-833-762-0876**

## **Utilization Management**

### **Preauthorization and Clinical Review**

To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty provider or other healthcare provider. Your insurance card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a pre-authorization request does not meet Plan and nationally accepted medical criteria, you and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over \$1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

All preauthorizations and clinical review services are conducted by Quantum Health. Care Coordinators will assist you in understanding what services require preauthorization.

**For preauthorization, Providers should call the number listed on the insurance card.**

### **Concurrent Utilization Review**

Quantum Health will regularly monitor an inpatient hospital stay, other institutional admission, or ongoing course of care, and evaluate the appropriateness of the level of care and if the stay is meeting medical necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. Quantum Health will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and you and/or family to monitor the Covered Member's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, Quantum Health, and nationally accepted medical criteria.

## **Personal Care Guide Management**

Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the you, your family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on your treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on your physical and emotional needs.

The Personal Care Guide will look at your psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate your financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with you would occur at least monthly, if not more frequently, and continue until your health goals and needs are met.

The primary Personal Care Guide nurse will align with you and be the single point of contact them, and their family and caregivers, and providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network providers
- Encourage provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening

**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 Claim Administrator. 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 Claim Administrator 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 Claim Administrator no later than 2 business days or as soon as reasonably possible after the admission has occurred.
- **Maternity Admission Review (MSA):** 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 Claim Administrator *prior to* your maternity admission, you should call as soon as you find out you are pregnant, so the Claim Administrator will begin to monitor your case. Call the toll-free telephone number on your ID Card to contact the maternity program.

- **Other Admissions:** Whenever an admission to the following health care Services are recommended by your Physician, you must call the Claim Administrator.
  - 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 Claim Administrator, a Case Manager may be assigned to you for the duration of your care. Call the toll-free telephone number on your ID Card to contact the Claim Administrator.

**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 the Claim Administrator will send you a letter confirming that you or your representative called to report the admission. 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 Claim Administrator. 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 Care Coordinator can make the decision whether Inpatient care or other health care services or supplies are not Medically Necessary. Should the Care Coordinator'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 Care Coordinator 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 Care Coordinator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued Hospitalization or other health care service is Medically Necessary for purposes of the Plan (i.e., whether benefits will be paid by the Plan).

In the event that the Care Coordinator 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 as determined by the Care Coordinator. 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 Care Coordinator's Physician decide they were not Medically Necessary.

#### **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.

#### **INFORMATION AND RECORDS**

It is your personal responsibility to ensure that any Provider, other the Claim Administrator, 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, the Claim Administrators, 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 Westpath 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.

#### **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.

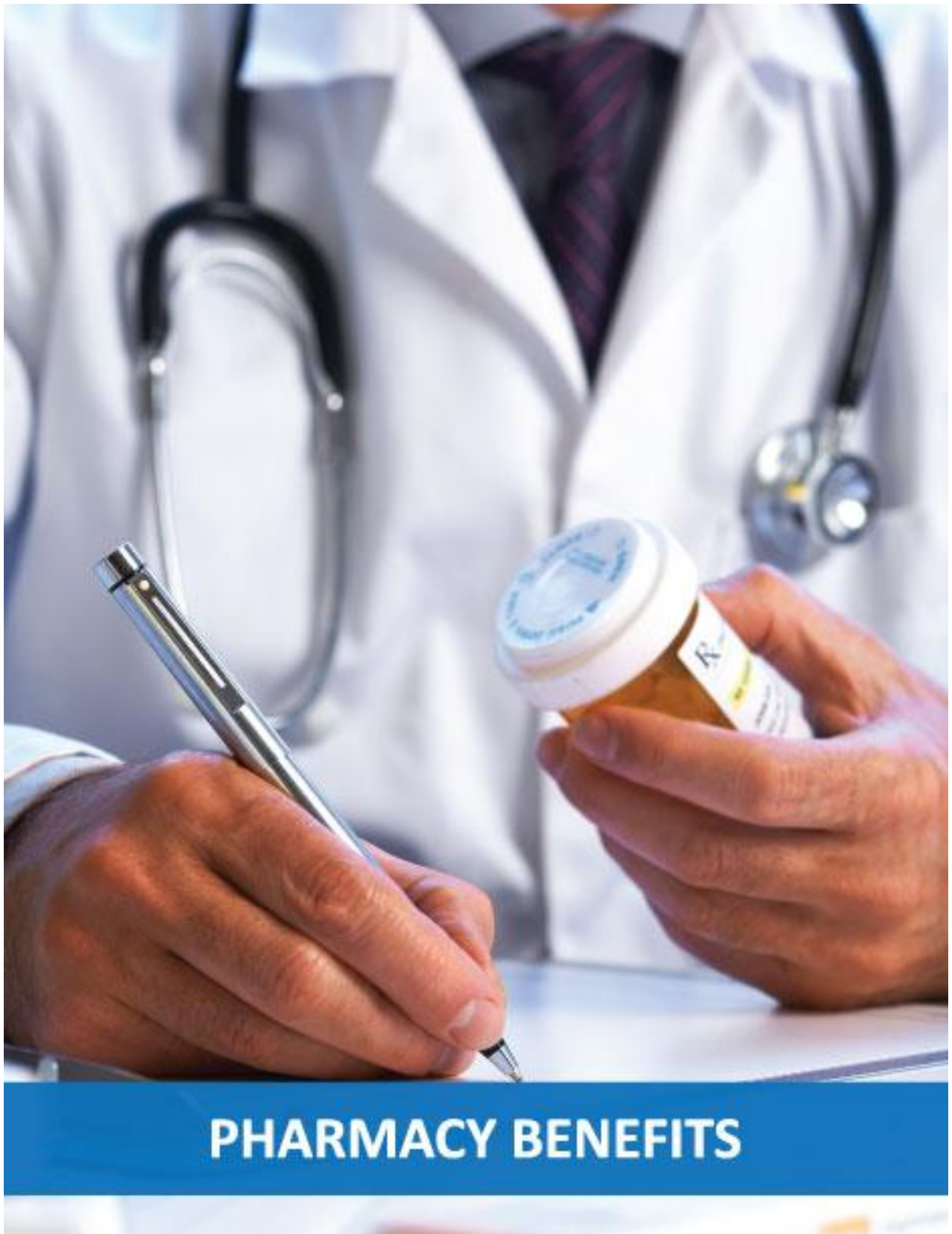
If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Claims Administrator may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Claims Administrator 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. The rebates are used to reduce expenses of the Plan.

**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.



## PHARMACY BENEFITS

### 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. Do **not** send claims for Prescription Drug benefits to the Claims Administrator for medical and behavioral health benefits. Prescription Drugs received while inpatient and certain prescription drugs received in a physician's office may be covered under the medical/behavioral health benefit.

There are three ways to fill your outpatient 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/Benefits Access portal. Go to [BenefitsAccess.org](https://www.benefitsaccess.org), click on "**HealthFlex/Benefits Access**" and enter your Benefits Access username and password.

You must present your 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.

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.

***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.

Please review this section carefully for additional information about Prescription Drug benefits under the Plan.

## Schedule of Benefits

Plan	H2000 with HSA		H2500 with HSA		H5000 with HSA	C2000 with HRA and C3000 with HRA		B1000	
Deductible	\$2,000 individual \$4,000 family		\$2,500 individual \$5,000 family		\$5,000 individual \$10,000 family	None		None	
Annual Out-of-Pocket (OOP)Maximum — Combined Medical, Behavioral and Pharmacy Costs	In Network \$5,000 individual \$10,000 family		In Network \$5,000 individual \$10,000 family		In Network \$5,000 individual \$10,000 family	In Network With both medical plans \$5,000 individual \$10,000 family		In Network \$5,000 individual \$10,000 family	
Amounts shown: Participant pays  Co-Payments— Generic  Preferred Brand- Name  • Minimum  • Maximum  Non-Preferred Brand-Name  • Minimum  • Maximum	H2000		H2500		H5000	C2000 and C3000		B1000	
	30-Day	90-Day	30-Day	90-Day	Participant pays 0% after meeting deductible; preventive drugs are not subject to deductible and have the same copayments as other HealthFlex plans	30-Day	90-Day	30-Day	90-Day
	\$10*	\$25*	\$10*	\$25*		\$10	\$25	\$10	\$25
	30%*	30%*	30%*	30%*		30%	30%	30%	30%
	\$30*	\$75*	\$30*	\$75*		\$30	\$75	\$30	\$75
	\$65*	\$165*	\$65*	\$165*		\$65	\$165	\$65	\$165
	40%*	40%*	40%*	40%*		40%	40%	40%	40%
	\$50*	\$125*	\$50*	\$125*		\$50	\$125	\$50	\$125
	\$120*	\$300*	\$120*	\$300*		\$120	\$300	\$120	\$300
<p><sup>1</sup> <b>Standard Deductible:</b> Assumes participant and covered spouse (if applicable) met Health Check incentive requirement in the prior year. If not taken, the deductible will be increased by \$250 for individual and \$500 for family deductible. Households with family coverage in the H5000 plan who do not complete the Health Check in the prior year will have their deductible and individual out-of-pocket maximum increased by \$500 so the deductible does not exceed the individual out-of-pocket max.</p> <p>* Co-payments/co-insurance apply after deductible has been met for most drugs. Deductible does not need to be met for medications on the OptumRx preventive drug list.</p>									

## **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 not on the formulary, including nonprescription drugs, investigational and experimental drugs and drugs that are not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for treatment of the particular condition in standard reference compendia or medical literature are excluded from coverage. Excluded medications 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.

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/Benefits Access 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*.

## **Rx Drug Formulary**

### **SHOULD I USE OPTUMRX HOME DELIVERY OR A RETAIL PHARMACY?**

When you need a Prescription Drug for a limited time (<3 months), 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.

### ***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 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 access the OptumRx website via Benefits Access. 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 prior authorization or additional information 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 Benefits Access website. Go to [BenefitsAccess.org](https://BenefitsAccess.org) and enter your username and password. Then select the **Health** menu click **Prescription Drugs** in the top bar or **Go To OptumRx** under **Prescription Drugs** on the left side of the page. You won't need to enter another username/password to refill prescriptions or check the status of your claim.

#### **OTHER RX PLAN FEATURES**

**Point-of-Sale Rebates:** Certain drug manufacturers provide rebates on the purchase of their prescription drugs. The price of the drug will be adjusted when you purchase it to reflect the rebate credit. This means the out-of-pocket cost you pay at your pharmacy may be lower going forward if your prescription drug is eligible for a rebate.

**Specialty Medication Manufacturer Coupons** (commonly referred to as "copay cards"): If you use a coupon provided to you by a prescription drug manufacturer when purchasing specialty medication at Optum Specialty Pharmacy, you will only receive credit towards your deductible and out-of-pocket maximum for the amount you actually pay out-of-pocket when you purchase the drug. You will not receive credit for the amount of the coupon because you did not pay that amount. You can still use the coupon to reduce your out-of-pocket cost for that medication.

Health Flex includes a number of drug utilization management programs to maximize safety and cost efficiencies. These include:

**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 request 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 an amount equal to the applicable Generic Drug Cost Share plus the cost difference between the Brand-Name Drug and the Generic Drug, unless it is medically necessary for you to take the Brand-Name medication, as documented by your provider and approved by OptumRx.

If you have questions or concerns about generic medication, speak to your Physician or your Pharmacist for more information. You may also call the OptumRx member service number at **1-855-239-8471** to speak with a registered Pharmacist.



**Maintenance Medication Requirement:** The Plan requires that maintenance (long-term) medications be filled in 90-day refills at either the OptumRx Home Delivery Pharmacy or a Walgreens Retail 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 cost share for a 90-day supply of medications. *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.*

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 maintenance medication, even if each fill is for less than 30 days.

**Prior Authorization and Step Therapy Programs:** Some medications are only covered for specific medical conditions or for a specific quantity and duration based on available evidence, reviewed by external physicians and pharmacists on OptumRx's Pharmacy and Therapeutics (P&T) Committee. OptumRx, in cooperation with your physician, determines the coverage based on clinical guidelines. Prior authorization may include: quantity limits, step therapy (trial and failure of one or more first-line medications before a medication will be covered), or restriction of coverage to certain populations or conditions for which evidence suggests effectiveness.

**Preventive Drug List:** The Preventive Drug List defines certain preventive formulary medications that OptumRx has determined qualify as "preventive" under IRS guidelines. Wespath does not choose which medications are considered preventive. The medications on the Preventive Drug List are categorized based on the medical conditions that they are used to prevent. The Plan will pay for a portion of medications on the Preventive Drug List even if the deductible has not been met in an HSA Plan (H2000, H2500, H5000).

[2024 Preventive Drug List](#)

## **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 have special shipping and handling needs or require injection. The OptumRx Specialty Pharmacy service is designed to help you meet the particular needs and challenges of using certain Prescription Drugs as well as providing careful clinical management and more favorable pricing for Specialty medications, which are often costly and may require consistent adherence in order to be effective. Therefore, the Plan requires that certain Specialty medications (as defined by the Claim Administrator, OptumRx) be filled at OptumRx's specialty pharmacy. Fills of the Specialty drugs 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:

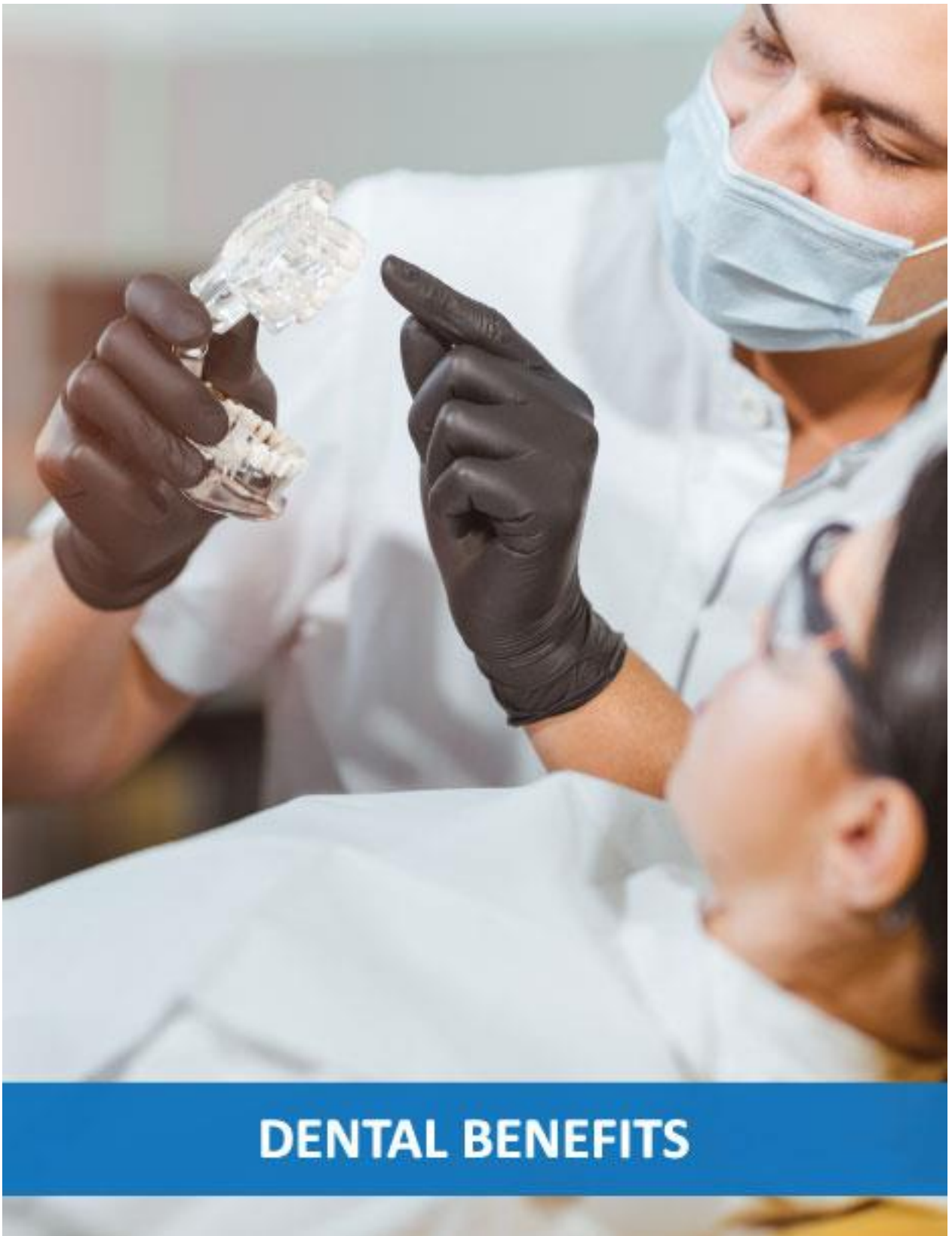
- Support from OptumRx nurses and Pharmacists who are trained in specialty Prescription Drugs, their side effects, and the conditions they treat.
- Expedited delivery to your home or your Physician's office for all of your Special Care Prescription Drugs.
- Some supplemental supplies, such as needles 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 Optum Specialty Pharmacy in 30-day supplies to avoid waste if medication changes are required.

### ***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.



## DENTAL BENEFITS

## DENTAL BENEFITS

Participants may select a Dental Benefit Option through HealthFlex. 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.

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](http://cigna.com). You also can log into [BenefitsAccess.org](http://BenefitsAccess.org), follow the menu to **Health** and then **Dental** benefits.

**Eligibility for Reimbursement from HealthFlex Accounts:** dental expenses not otherwise covered can be reimbursed from a Participant's FSA (full-use or limited-use), HRA, or HSA.

### Benefit Options

HealthFlex offers three coverage options for dental benefits: 1) Passive PPO 2000, 2) Dental PPO; or 3) Dental HMO (DHMO).

### DENTAL NETWORKS

The Passive PPO 2000 and Dental PPO use Cigna's **PPO Advantage Network**; these plans offer in-network and out-of-network benefits. A "passive" PPO allows you to benefit from discounts when receiving services from a PPO Advantage network provider—without a reduction in benefits if you choose to go out of network. The PPO has lower benefits for going out of network. All out-of-network reimbursement levels are based on 90th percentile of reasonable and customary allowance.

The Dental HMO uses the Cigna **Dental Care Access Plus Network** and offers no out-of-network benefits. Visit [cigna.com](http://cigna.com) to search for in-network providers.

Network Benefits	Passive PPO 2000	Dental PPO		Dental HMO
		PPO Advantage Network	Out of Network	
<b>Calendar Year Maximum*</b> (Class I, II and III expenses)		Year 1: \$2,000	Year 1: \$1000	No benefit maximum
	Year 2: \$2,150 <sup>1</sup>	Year 2: \$2,150 <sup>1</sup>	Year 2: \$1,150 <sup>1</sup>	
	Year 3: \$2,300 <sup>1</sup>	Year 3: \$2,300 <sup>1</sup>	Year 3: \$1,300 <sup>1</sup>	
	Year 4 and beyond: \$2,450 <sup>1</sup>	Year 4 and beyond: \$2,450 <sup>1</sup>	Year 4 and beyond: \$1,450 <sup>1</sup>	
<b>Annual Deductible</b> • Individual • Family	• \$50 per person • \$150 per family	• \$50 per person • \$150 per family	• \$50 per person • \$150 per family	No deductible

*\*Preventive dental services are applicable to the annual benefit maximum*

<sup>1</sup>Only the Dental PPO and the Passive PPO 2000 include Cigna Dental Wellness Plus<sup>SM</sup> features. When you or your family members receive any preventive care in one plan year, the annual dollar maximum for individuals who meet the preventive care requirements will increase by \$150 for the following plan year, up to \$450.

## Dental Benefit Overview

Network Benefits	Passive PPO 2000	Dental PPO		Dental HMO (Shows Participant Cost)
		PPO Advantage Network	Out of Network <sup>4</sup>	
<b>Class I—Preventive and Diagnostic Care</b> Oral evaluation, routine cleanings, x-rays, sealants	Plan pays 100% Not subject to deductible	Plan pays 100%	Plan pays 100%	Periodic/comprehensive oral evaluation; prophylaxis: \$0 Sealant: \$12 per tooth Routine cleaning: First two are free; additional cleanings \$45 X-rays panoramic (every 3 years) or bitewings: \$0
<b>Class II—Basic Restorative</b> Fillings, endodontics, periodontics, oral surgery, anesthesia, bridge/crown/ denture repair	Plan pays 80% Subject to deductible	Plan pays 90%	Plan pays 70%	Each amalgam filling, anterior composite filling: \$0 Posterior composite filling: \$47 – \$115 Oral surgery: Extractions \$12 per tooth; removal of impacted tooth: \$46–\$125 per tooth Anesthesia: \$190 for the first 30 minutes; \$84 each additional 15 minutes Molar root canal: \$335 Periodontal scaling/root plane: \$42–\$83 per quad
<b>Class III—Major Restorative</b> Crowns, dentures, implants	Plan pays 50% Subject to deductible	Plan pays 60%	Plan pays 50%	Crown: \$88 – \$150, plus \$410 – \$460 for materials Partial dentures: \$525 – \$715
<b>Class IV—Orthodontia</b>	Plan pays 50% up to \$2,000 (up to age 19) Subject to lifetime maximum	Plan pays 50% up to \$2,000 (up to age 19)	Plan pays 50% up to \$1,000 (up to age 19)	Child orthodontics: \$2,040 Adult orthodontics: \$2,376

<sup>1</sup> Increase contingent upon receiving Preventive Services in Plan Year 1.

<sup>2</sup> Increase contingent upon receiving Preventive Services in Plan Years 1 and 2.

<sup>3</sup> Increase contingent upon receiving Preventive Services in Plan Years 1, 2 and 3.

<sup>4</sup> Benefits for out-of-network provider is based on 90<sup>th</sup> percentile of reasonable and customary allowances.

The annual deductible and co-insurance amounts are your share to pay and do not apply toward the satisfaction of your Deductible or Out-of-Pocket Maximum for medical benefits. All other benefits shown are the amounts or percentages that the plan pays for a service.

Cost share for the Dental HMO is listed in the full payment schedule available here: [DHMO Schedule](#)

### Orthodontic Coverage Restrictions—PPO and Passive PPO

The PPO and Passive PPO plans do **not** cover any Orthodontic services or supplies for any Participant or other Covered Person that is not a Dependent child less than 19 years of age.

The total amount payable for all expenses incurred for Orthodontics for a Dependent child less than 19 years of age during his or her lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Payments for comprehensive full-banded orthodontic treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3-month period. In determining the first installment, CIGNA assigns 25% of the charge for the entire course of treatment to the appliance. The remainder of such charge is prorated over the estimated duration of such treatment. These payments are made only for services performed while such child is covered. If coverage or treatment of such child ceases, the amount payable for that 3-month period will be prorated.

Orthodontia in progress is covered under the standard orthodontia benefit. The plan will begin coverage from the effective date of the plan throughout the remaining course of treatment. Expenses for treatment received prior to the effective date would be excluded. The benefit maximum available will depend on the specific treatment plan, total cost and length of treatment remaining.

### General Limitations and Exclusions for Dental Benefits

<b>Limitations:</b>	
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	2 per calendar year
Periodontal Maintenance	2 per calendar year following active therapy
Fluoride Application	2 per calendar year, no age limitation
Sealants (per tooth)	Limited to posterior tooth. 2 treatments per tooth every 12 months, no age limitation
Space Maintainers	Limited to non-orthodontic treatment, no age limitation
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No additional coverage for porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Subject to review for more than one occurrence
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No additional coverage for porcelain or white/tooth colored material on molar crowns or bridges.

### Dental Benefit Exclusions

No benefits are available for the following products and services. If medically necessary, some of these may be covered by the medical benefit:

- Charges that exceed the annual benefit maximum;
- Procedures and services not included in the list of covered dental expenses;

- Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;
- Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;
- Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs
- Charges in excess of the Maximum Reimbursable Charge.
- 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;
- 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.
- If a service is tooth/gum related Cigna would review for coverage under the dental plan. Such as an abscess or bone where malignancy is suspected;
- Accidental injury to sound natural tooth;
- Services not related to the tooth or gum, for example cheek/tongue
- Charges made for dental services rendered by a dentist that are required as the result of an accidental injury.
-







## VISION BENEFITS

The Plan provides your vision benefits through Vision Service Plan Insurance Company (VSP). VSP fully insures the vision benefits under the Plan, in addition to serving as the Claims Administrator. 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](http://vsp.com). You also can log into [BenefitsAccess.org](http://BenefitsAccess.org) and follow the menu to **Health** and then **Vision** benefits.

**Eligibility for Reimbursement from HealthFlex Accounts:** vision expenses not otherwise covered can be reimbursed from a Participant's FSA (full-use or limited-use), HRA, or HSA.

### **Benefit Options**

HealthFlex offers three coverage options for vision benefits: 1) Exam Core, 2) Full Service; or 3) Premier.

The co-payment amounts are your share to pay and do not apply toward the satisfaction of your Deductible or Out-of-Pocket Maximum for medical benefits. All other benefits shown are the amounts that the plan pays for a service.

Benefit	Exam Core	Full-Service	Premier
<b>WellVision Exam</b> <i>Description</i> <ul style="list-style-type: none"> <li>• Focuses on your eyes and overall wellness</li> <li>• Every 12 months</li> </ul>	\$20 co-payment	\$20 co-payment	\$20 co-payment
<b>Prescription Glasses</b>	No coverage	\$20 co-payment	\$20 co-payment (applies to 1 <sup>st</sup> and 2 <sup>nd</sup> pair of glasses)
<b>Frame Details</b>	No coverage	<ul style="list-style-type: none"> <li>• Includes \$160 allowance for wide selection of frames</li> <li>• 20% savings on any amount over your allowance</li> <li>• Every 12 months</li> </ul>	<ul style="list-style-type: none"> <li>• Includes \$200 allowance for wide selection of frames</li> <li>• 20% savings on any amount over your allowance</li> <li>• Every 12 months</li> </ul>
<b>Lens Details</b>	No coverage	<ul style="list-style-type: none"> <li>• Includes single vision, lined bifocal and lined trifocal lenses</li> <li>• Includes polycarbonate lenses for dependent children</li> <li>• Every 12 months</li> </ul>	<ul style="list-style-type: none"> <li>• Includes single vision, lined bifocal and lined trifocal lenses</li> <li>• Includes polycarbonate lenses for dependent children</li> <li>• Every 12 months</li> </ul>
<b>Lens Enhancements</b>	No coverage	<ul style="list-style-type: none"> <li>• Standard progressive lenses: 100%</li> <li>• Average savings of 25%–30% on other lens enhancements</li> <li>• Every 12 months</li> </ul>	<ul style="list-style-type: none"> <li>• Anti-reflective coating: Covered in full after \$25 copay</li> <li>• UV Protection: 100%</li> <li>• Standard progressive lenses: 100%</li> <li>• Average savings of 40% on other lens enhancements</li> <li>• Every 12 months</li> </ul>
<b>Contact Lenses</b>	No coverage	<i>Instead of glasses</i> <ul style="list-style-type: none"> <li>• Includes \$160 allowance for contacts and contact lens exam (fitting and evaluation)</li> <li>• 15% off contact lens exam up to a maximum \$50 copay</li> <li>• Every 12 months</li> </ul>	<i>In addition to glasses</i> <ul style="list-style-type: none"> <li>• Includes \$200 allowance for 2<sup>nd</sup> pair of glasses, or contacts and contact lens exam fitting and evaluation</li> <li>• 15% off contact lens exam up to a maximum \$50 copay</li> <li>• Every 12 months</li> </ul>

Benefit	Exam Core	Full-Service	Premier
<b>Additional Coverage</b>	NA	Diabetes Eyecare Plus Program: \$20 co-payment	Diabetes Eyecare Plus Program: \$20 co-payment
<b>Out-of-Network Coverage (maximum paid by plan)</b>	No coverage	<ul style="list-style-type: none"> <li>• Exam up to \$45</li> <li>• Frame up to \$70</li> <li>• Single vision lenses up to \$30</li> <li>• Lined bifocal lenses up to \$50</li> <li>• Lined trifocal lenses up to \$65</li> <li>• Progressive lenses up to \$50</li> </ul> Contacts up to \$105	<ul style="list-style-type: none"> <li>• Exam up to \$45</li> <li>• Frame up to \$70</li> <li>• Single vision lenses up to \$30</li> <li>• Lined bifocal lenses up to \$50</li> <li>• Lined trifocal lenses up to \$65</li> <li>• Progressive lenses up to \$50</li> </ul> Contacts up to \$105
<b>Extra Savings</b>	<ul style="list-style-type: none"> <li>• 20% savings on complete pair of prescription glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your WellVision Exam</li> </ul> 15% savings on a contact lens exam (fitting and evaluation)	<ul style="list-style-type: none"> <li>• Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details</li> <li>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your WellVision Exam</li> <li>• No more than \$39 co-payment on routine retinal screening as an enhancement to a WellVision Exam</li> </ul> Average 15% off the regular price or 5% off the promotional price; discounts only from contracted facilities	<ul style="list-style-type: none"> <li>• Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details</li> <li>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your WellVision Exam</li> <li>• No more than \$39 co-payment on routine retinal screening as an enhancement to a WellVision Exam</li> </ul> Average 15% off the regular price or 5% off the promotional price; discounts only from contracted facilities
<b>Laser Vision Correction</b>	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facility	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facility	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facility

### **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. Some options will require an additional charge over the covered benefit. You must pay these additional charges directly to the Provider. Discounts for VSP customers may be available.

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.

### **Medically Necessary Contact Lenses\***

Medically necessary contact lenses are non-elective contact lenses prescribed when certain medical conditions hinder vision correction through regular eyeglasses and contact lenses are the accepted standard of treatment. With some medical conditions, patients are unable to achieve a specified level of visual acuity or performance through regular eyeglasses. This results in the need for “medically necessary contact lenses.”

Such medical conditions include:

- **Aphakia** – the removal or absence of the lens of the eye(s) due to surgery, injury, or abnormality.
- **Anisometropia** – a refractive condition where the eyes have unequal focus or optical power
- **Keratoconus** – an eye disease that causes structural damage to the eye’s cornea, changing from the normal, round shape to a bulging, cone shape.

\* Coverage for medically necessary contact lenses under the Full Service and Premier plan may exceed the documented benefit for traditional contact lenses. Medically necessary contact lenses are not covered under the Exam Only Vision plan.

### **Vision Expenses Not Covered**

No benefits are available for the following products and services. If medically necessary, medical/surgical treatment of the eyes be covered by the medical benefit:

- 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*.



## REIMBURSEMENT ACCOUNTS

## REIMBURSEMENT ACCOUNTS

HealthFlex offers several reimbursement accounts for health or dependent care expenses as part of the Plan. Details of the different accounts are below.

### **FLEXIBLE SPENDING ACCOUNTS (FSAs)**

Through HealthFlex, actively working participants have the option to elect to contribute a part of their compensation to tax-advantaged (pre-tax) flexible spending accounts (FSAs)—one for health care expenses (health care FSA) and one for dependent day care expenses (dependent care FSA).

If you elect to participate in an FSA, you may contribute part of your compensation, i.e., set aside funds, on a before-tax basis<sup>1</sup> to reimburse yourself for certain eligible health care and dependent care expenses. Flexible spending accounts can save you significant amounts on the cost of health care and dependent day care by allowing you to pay for qualified expenses on a pre-tax basis. However, the funds you set aside in flexible spending accounts are subject to certain restrictions on their use, as explained below, and are subject to the Internal Revenue Service (IRS) “use it or lose it” rule. Please be sure you understand all the implications of those rules to avoid losing funds.

When you elect to contribute to an FSA, you are choosing to contribute that amount over the applicable plan year— which is a calendar year—not a conference or appointment year. If you enroll in the plan mid-year and elect to contribute to an FSA, your election will apply to the remaining portion of the calendar year.

HealthFlex flexible spending accounts are administered by HealthEquity®.

Reimbursement accounts are subject to strict rules and requirements of the Code, under §105, §106, §125 and §129. FSAs can only reimburse you for eligible health care expenses or dependent day care expenses. The Plan maintains FSAs as bookkeeping entries, with the “account balance” representing the amount of your salary reduction contributions that are available to reimburse your eligible expenses.

To participate in the FSAs, you must be enrolled in the Plan and covered in a medical Benefit Option. For each year in which you want to have an FSA, you must make an election to contribute a portion of your salary. If you do not elect an amount for the FSAs during the Annual Election Period or special Life Event enrollment period for any Plan Year, you are presumed to have made an election to contribute zero dollars. FSA elections do not carry over from one year to the next; they are not “evergreen.”

FSAs can help you save significantly on the cost of health care and dependent care by allowing you to pay for qualified expenses on a tax-advantaged basis. However, the funds you contribute are subject to certain restrictions in their use, as explained below, and are subject to the “*use-it-or-lose-it*” rule.

### **The Use It or Lose It Rule**

FSAs have certain “use it or lose it” rules, based on Internal Revenue Service (IRS) guidelines. This means that account balances not spent by the specified deadline will be forfeited. In other words, if you don’t “use” your FSA money by the deadline, you will “lose” it. The “use it or lose it” rule applies to any unspent amount remaining for the dependent care FSA and to any amount over \$660 remaining for the health care FSA at the end of the plan year. (See details below.)

**Important: Amounts remaining in health care FSA (over \$660) and dependent care FSA (any amount) accounts after the applicable deadlines will be forfeited due to the IRS “use it or lose it” rule. HealthFlex uses such forfeitures to offset the administrative expenses of the program.**

Use it or lose it rules for health and dependent care FSAs are different, as described below.

Health Care FSA (eligible health care expenses):

- You must spend all but \$660 of your FSA by December 31 of the current plan year or it will be lost. After December 31, you can carry over up to \$660 remaining in your FSA account—to be spent by December 31 of the following year. Any balance in your FSA account over \$660 as of December 31 of the following year will be forfeited.
- Claims for the current plan year must be submitted by April 30 of the next following year or they will not be reimbursed.

Dependent Care FSA (eligible dependent care expenses):

- You must incur all eligible expenses by December 31 of the FSA year. There is no grace period or carry-over allowance.
- Claims must be submitted by April 30 of the following year.

**HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)**

If you elect a health care FSA, you can elect to set aside part of your compensation on a before-tax basis<sup>1</sup> to reimburse yourself for certain eligible health care expenses that are not otherwise reimbursed or reimbursable from the group health plan component of HealthFlex or from some other source. The entire amount you elect is available on the first day of the plan year, which can be useful to cover out-of-pocket expenses<sup>2</sup> before the deductible has been met. Paycheck deductions continue over the course of the year.

With a health care FSA, you may submit for reimbursement certain eligible out-of-pocket medical, pharmacy, dental, vision, over-the-counter medication and medical supply, and menstrual product expenses incurred during the plan year<sup>2</sup>. You also may submit for reimbursement through the health care FSA certain expenses incurred by your spouse or dependent children (even for qualified expenses for qualified dependents not covered under the HealthFlex medical plan). To get an idea of the amount you may want to set aside in a health care FSA, begin with last year's medical, dental and vision expenses. Will any of these recur? If so, add them to your estimate. You may then want to consider what types of expenses you can anticipate for the coming year, such as new eyeglasses, any co-payments or deductibles under the benefit options you elect. This will help you estimate the amount of your compensation that you may want to set aside. For further information regarding eligible expenses, please call HealthEquity at 1-877-924-3967 or log into BenefitsAccess.org, select the "Health" tab, then click "Health & Reimbursement Accounts."

<sup>1</sup> Salary reduction contributions are not subject to federal income tax or FICA tax withholdings. In some cases, salary reduction contributions may not be subject to certain state and local tax withholdings. Consult your tax advisor and plan sponsor

<sup>2</sup> With an HSA plan, the health care FSA would be limited-use, which means it may be used for dental and vision expenses only, until you notify HealthEquity that you have reached the IRS-defined deductible; then can be used for all eligible health care expenses. (2025 IRS-defined deductible: \$1,650 individual coverage/\$3,300 family coverage.)

It is relatively easy to estimate your expenses for a health care FSA since you probably already know the cost of many services in advance. You may set aside \$300 to \$3,300 (2025) per calendar year.



### **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)**

If you elect a dependent care FSA, you may elect to set aside part of your compensation on a before-tax basis<sup>1</sup> to reimburse yourself for certain eligible dependent day care expenses (even for qualified expenses for qualified dependents who are not covered under the HealthFlex medical plan). The dependent care FSA applies only to expenses incurred that calendar year (i.e., January 1 through December 31).

With a dependent care FSA, you may submit for reimbursement certain expenses incurred for care of your dependents to enable you and your spouse to be gainfully employed. Dependent day care expenses may include expenses for summer day camp, babysitting services while you work, or a day care center for eligible children or dependent adults.

If you incur dependent day care expenses for your dependent children (age 12 and younger<sup>3</sup>) or for your spouse or other adult dependents who are physically or mentally incapable of self-care, you may be reimbursed for certain eligible dependent day care expenses under the dependent care FSA. Unlike the health care FSA, only the funds that have actually been deducted from your compensation to date are available to reimburse expenses.

Make sure to keep track of your dependent day care expenses and the provider's name, address and tax identification number (Social Security number if it is a home provider). In addition to submitting this information to HealthEquity to request your reimbursement, you may want to save a copy of this information for reference when you prepare your tax return.

In a calendar year, the amount an employee can exclude from his or her income through salary deferrals to the dependent care FSA is limited to the smallest of the following:

1. \$5,000 (\$2,500 if the employee is married, but filing separately);
2. the employee's earned income if less than \$5,000; or
3. the spouse's earned income if the employee is married at the end of the taxable year.

If the employee is married and his or her spouse is either a full-time student or incapable of self-care and has no earned income, the spouse is deemed to have an earned income of \$250 per month (\$500 per month if there are two or more qualifying individuals) in each month that the spouse is either a full-time student or incapable of self-care.

Certain types of expenses are not eligible for reimbursement under the dependent care FSA. Examples of ineligible expenses include:

- services that are primarily educational or medical in nature (pre-school is generally regarded as primarily for the child's well-being and protection and not primarily educational);
- educational expenses at kindergarten level or higher;
- services provided on behalf of a qualified dependent while you or your Spouse is not working;
- household services provided by individuals who are not responsible for providing care to the dependent; and
- overnight camp costs.

<sup>1</sup> Salary reduction contributions are not subject to federal income tax or FICA tax withholdings. In some cases, salary reduction contributions may not be subject to certain state and local tax withholdings. Consult your tax advisor and plan sponsor

<sup>3</sup> Your child will cease to be an eligible dependent for dependent care FSA purposes the day that he or she reaches age 13.

**Dependent Care FSA vs. Dependent Care Tax Credit?**

Any reimbursements received through the dependent care FSA are not eligible for the Dependent Care Tax Credit on your personal income tax return and dependent care FSA reimbursements can reduce the amount of eligible expenses that you can claim under the Dependent Care Tax Credit. You should speak to a tax adviser to determine if a dependent care FSA or the Dependent Care Tax Credit is more advantageous to you.

**Tax Reporting**

Although you will not have to pay federal, Social Security (FICA) or state (except in a few states) taxes on amounts you contribute to the dependent care FSA, the amount you are reimbursed should be recorded in a separate box on your Form *W-2*. When preparing your personal income tax return, you should complete and file an IRS *Form 2441* or *Schedule 2*; depending on the type of income tax return you file (*Form 1040* or *1040A*). *Form 2441* or *Schedule 2* requires that you report the name, address and taxpayer ID number of your dependent care providers. These forms allow the IRS to identify dependent care reimbursements received through the dependent care FSA and to calculate any expense which may remain eligible for the Dependent Care Tax Credit. For more information about income tax filing requirements related to the dependent care FSA, you should review *IRS Publication 503* or consult with a tax professional.

**HEALTH REIMBURSEMENT ACCOUNT (HRA)**

HealthFlex offers Health Reimbursement Account (HRA) Benefit Options. An HRA plan is a type of health insurance plan that allows you as a Participant to use a Health Reimbursement Account (HRA) to pay certain eligible health care expenses directly.

An HRA can be used to pay for eligible unreimbursed expenses incurred by you or your covered Dependents on a nontaxable basis (i.e., the contributions to the HRA from the Plan and your Plan Sponsor generally are not taxable). If you do not use all HRA funds during a Plan Year, the remaining amount will roll over to the following Plan Year, with no maximum on accumulated rolled-over funds as long as you continue participation in the HRA plan or meet other requirements for HRA eligibility. You are only eligible for the HRA if you have elected and are enrolled in a HRA plan under HealthFlex. Certain individuals in the PPO Benefit Option may also receive Excess Premium Credit in an HRA.

HRA balances remaining when you retire may be used to the extent allowed under the law for eligible health care-related expenses, including health coverage in retirement through Medicare, and Medicare supplement plans. To be eligible, you must satisfy the retiree eligibility rules of both HealthFlex and your Plan Sponsor. Your HRA balance will be available for your use even if your Plan Sponsor does not sponsor health coverage for retired Participants through the Plan or Wespeth.

**HRA Funding**

Each year Wespeth will determine the amount that will be contributed to your HRA for the Plan Year based on the design of the plan you elect and/or your excess Premium Credit. You can find information on the amount of HRA funding in the applicable Schedules in the *Medical and Behavioral Health Benefits Information* section

If you become disabled or are working for a small employer in the Medicare Secondary Payer Small Employer Exception (MSPSEE) program and as a result are enrolled in a Medicare supplement plan, contributions to your HRA will cease, though you may still meet the requirements to be reimbursed from the account. If you remain in a Benefit Option for active Participants, HRA funding will continue.

### **HRA Tax Reporting**

HRAs are funded solely by the plan sponsor; employees may not make contributions to their HRA. Contributions to an HRA are not included in the employee's income and are not reported on the IRS *Form W-2*. Employees do not pay federal income taxes or employment taxes on the contributions made to their HRA.

### **HRA Reimbursements**

The HRA allows reimbursement only for eligible medical expenses of you and your Dependents who are covered by the HealthFlex Plan. To be an eligible expense, you cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; and you cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to you and you cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Co-insurance amounts, Deductibles and out-of-network charges are reimbursable. In addition, medical expenses described in §213(d) of the Code are eligible for reimbursement from the HRA. Additionally, the costs of some over-the-counter medications are reimbursable.

In addition, if you have a Retiree HRA as described below, you may request reimbursements for long-term care insurance, or any premiums for health and dental insurance or Medicare.

### **Expenses Not Eligible**

Importantly, you cannot use an HRA to pay for HealthFlex Required Contributions while you are a actively employed.

Expenses incurred by a Spouse or Dependent who is not covered in the HRA plan under the Plan are not eligible for reimbursement. You are responsible for ensuring that you do not submit claims for reimbursement for a non-covered Spouse or Dependent. You may contact Wespeth or the Claims Administrator, HealthEquity, for a list of permissible and impermissible HRA expenses.

### **Carryover of Accounts**

If any balance remains in your HRA for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall be carried over to reimburse you for eligible medical expenses incurred during a subsequent Plan Year, as long as you remain enrolled in the Plan or otherwise maintain eligibility for your HealthFlex HRA.

### **Opting Out of the HRA**

If you want to have medical coverage through the "Health Insurance Marketplace" under the Affordable Care Act (also known as federal or state "exchanges") and to be eligible for federal assistance (a premium tax credit) toward the purchase of a Marketplace plan (instead of a HealthFlex Plan), you can request to convert your HRA to a limited-use HRA, which may be used for dental and vision expenses; or you may opt out of your HRA, i.e., forfeit the remaining balance, in order to be eligible for the premium tax credit (if you are otherwise eligible). Having a full-use HRA balance with the Plan causes you to have "minimum essential coverage" under the Affordable Care Act, which renders you ineligible for a premium tax credit.

### **Retiree HRA**

If you retire pursuant to the retirement eligibility rules of the Plan and your Plan Sponsor, any remaining balance in your HRA Account will be converted and transferred to a Retiree HRA Account. As long as you remain eligible for a retiree HRA, you may be reimbursed from your Retiree HRA Account for eligible medical expenses until your account is exhausted. HRA amounts are carried over from Plan Year to Plan Year as long as you remain retired and have not died. Retiree HRA funds are limited to the retired Participant and Spouse or Dependents previously covered by HealthFlex. If your Spouse or other

Dependents are eligible to receive HRA funds after you retire, they may have a separate non-Retiree HRA opened in their names.

Upon your death, if you have an eligible surviving Spouse or eligible surviving Dependents, the eligible survivors may be reimbursed from your Retiree HRA Account for eligible medical expenses until the account is exhausted or until such survivors die. Expenses incurred by a Spouse or Dependent who are not covered in the Plan are not eligible for reimbursement. If you die with a balance in your account and have no eligible surviving Spouse or Dependents, the balance of such account is forfeited to the Plan.

#### **Termination of HRA Participation**

If you are no longer eligible to participate in HealthFlex as described below, and a balance remains in your HRA Account, the funds will be handled in the following way, subject to minimum balance forfeiture rules (*see table*):

<b>Change in Participant Status</b>	<b>Impact on HRA</b>
Participant leaves HealthFlex voluntarily without continuation coverage (including waiver of coverage, if permitted by plan sponsor)	HRA is available for 90 days following termination of coverage (including continuation coverage) or until it is exhausted—whichever is earlier. Any balance will be forfeited after the 90-day period.
Plan sponsor ceases to sponsor HealthFlex	After termination of coverage, HRA is available for 24 months or until HRA is exhausted—whichever is earlier. Any balance will be forfeited after the 24-month period. However, if Participant retires in accordance with HealthFlex Plan and HealthFlex Plan Sponsor rules prior to or during the 24-month period, the HRA balance becomes a Retiree HRA and remains available until it is exhausted or Participant dies.
A Participant transfers between HealthFlex Plan Sponsors with no gap in coverage	HRA balance rolls over and remains available under the new plan sponsor. If there is a gap in coverage, the HRA is available for 90 days following termination of coverage or until it is exhausted— whichever is earlier. Any balance will be forfeited after the 90-day period.
Participant retires from a HealthFlex Plan Sponsor	HRA balance becomes a Retiree HRA and remains available until it is exhausted or participant dies. If participant returns to active status, the HRA remains a Retiree HRA, even for new contributions, and it's the Participant's responsibility to follow any applicable IRS rules. If Participant is eligible for Via Benefits, the HRA is not combined with Via Benefits HRA. If dependents remain on HealthFlex, a new active HRA is opened for the dependents, if eligible for funding. Once the dependents terminate from HealthFlex, HRA is available for 90 days following termination of coverage (including continuation coverage) or until it is exhausted—whichever is earlier. Any balance will be forfeited after the 90-day period.
Participant with no dependents covered by HealthFlex dies	HRA is forfeited after a 180-day claims spend-down period. Only claims prior to the Participant's date of death are eligible.

Change in Participant Status	Impact on HRA
Participant with dependents covered by HealthFlex dies	The HRA remains available to all dependents covered in HealthFlex and is reassigned to the lead dependent. Once all dependents terminate from HealthFlex, HRA is available for 90 days following termination of coverage (including continuation coverage) or until it is exhausted—whichever is earlier. Any balance will be forfeited after the 90-day period
Participant involuntarily loses eligibility for HealthFlex due to a Plan Sponsor merger/realignment and new employer does not sponsor HealthFlex	After termination of coverage, HRA is available for 24 months or until HRA is exhausted—whichever is earlier. Any balance will be forfeited after the 24-month period. However, if Participant retires in accordance with HealthFlex Plan and HealthFlex Plan Sponsor rules prior to or during the 24-month period, the HRA balance becomes a Retiree HRA and remains available until it is exhausted or Participant dies
<b>Clergyperson</b> loses eligibility for HealthFlex but either remains appointed to, employed by, or a full member of a HealthFlex Plan Sponsor. (Also applies to clergy couple when primary Participant status switches from one to the other)	HRA is available through retirement until it is exhausted or Participant dies. If you terminate employment and membership from the HealthFlex Plan Sponsor, the HRA is available for 90 days following this termination or until it is exhausted—whichever is earlier. Any balance will be forfeited after the 90-day period.
<b>Lay employee</b> goes from full-time to part-time and loses HealthFlex eligibility	HRA is available for 90 days following the loss of eligibility or until it is exhausted—whichever is earlier. Any balance will be forfeited after the 90-day period.

If you terminate for any reason and then are rehired after a gap, you will be considered a new HRA Participant and not have access to historical HRA funds. However, if you go on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, Wespath will continue to maintain your benefits on the same terms and conditions as if you were still an active Employee. If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

#### **Small HRA Balances**

Notwithstanding the foregoing, if you have an HRA balance but are no longer enrolled in the Plan your HRA balance is \$100 or less, Wespath reserves the right to forfeit your remaining small balance and terminate the HRA completely with 90 days' notice. If you are a current participant not reasonably expected to receive a new HRA contribution and have an HRA balance \$100 or less, Wespath reserves the right to forfeit your remaining small balance with 90 days' notice.

#### **HEALTH SAVINGS ACCOUNT (HSA)**

HealthFlex offers Health Savings Account (HSA) Benefit Options. A HealthFlex HSA plan is considered a qualified high-deductible health plan by the IRS. It allows a Participant to use a Health Savings Account (HSA) to pay eligible health care expenses directly. In order to participate in the HSA offered through

HealthFlex, participants must agree to and accept the terms and conditions of the HSA and attest they are eligible to contribute to an HSA. Participants who are enrolled in any other plan, which is not a qualified high-deductible plan, are not eligible to make or receive HSA contributions, including HSA contributions included in the plan design or excess premium credit. This includes a spouse's plan, former employer's plan, Tricare, a full-use FSA or HRA, Medicaid, as well as participating in the Medicare Secondary Payer Small Employer Exception program, or are enrolled in Medicare Parts A and/or B due to retirement or disability. If you or your spouse become eligible for Medicare mid-year, you may be eligible to contribute a reduced amount to an HSA (prorated based on the amount of time you were not in Medicare). See HSA Contribution Limits below.

An HSA is used to offset eligible unreimbursed medical expenses incurred by the Participant or covered Dependents on a nontaxable basis (both Plan/employer and Participant contributions to the HSA generally are not taxable). HSAs can also be used for non-eligible medical expenses; however, any amount used for non-eligible expenses will be treated as taxable income and subject to an IRS-determined tax penalty if under age 65. Health Equity administers distributions based on what you report the reimbursement will be used to pay. You are responsible for keeping appropriate documentation in case of an audit by the IRS.

If HSA funds are not used during a Plan Year, the remaining amount will roll over to the following Plan Year, with no maximum on accumulated rolled-over funds. HSA balances remaining at retirement may be used to the extent allowed under the law for eligible health care-related expenses, including health coverage in retirement through Medicare plans outside of HealthFlex.

### **HSA Funding**

An HSA will be established for each eligible Participant in the HSA plan who does not opt out of the HSA and agrees to the terms and conditions of the HSA. Some HSA Benefit Options include HSA funding; in addition, the Participant can also elect to make pre-tax contributions into the HSA. Contributions included with the medical Benefit Option will be funded and available in full at the beginning of each Plan Year. Participant Contributions will be available monthly as they are made to the HSA.

Participants who are currently enrolled in the HSA plan and transfer to another Plan Sponsor that offers the HSA plan will not be eligible for an additional plan-provided HSA contribution. Any additional funding provided by the plan sponsor will be awarded based on plan sponsor criteria. In addition, the Participant's current HSA election will remain in place unless the Participant makes a new election; the election cannot be less than what was contributed to date. Participants who lose eligibility and become eligible again mid-year are not eligible for an additional plan-provided HSA contribution until the following Plan Year. Dependents who become Surviving Dependents or Divorced Spouses are not eligible for an additional HSA Plan Sponsor Contribution until the following Plan Year.

### **HSA Contribution Limits**

HSAs are subject to an annual IRS-established contribution limit. The contribution limit is based on single or family coverage. For 2025, the contribution limit is \$4,300 for single coverage and \$8,550 for family coverage. Participants age 55 and older can contribute an additional \$1,000 annually.

Participants who are enrolled into the HSA mid-year can either contribute under the IRS Last Month Rule or contribute a prorated amount based on the actual number of months in the HSA plan and eligible for the HSA. Under the Last Month Rule, the Participant can contribute the full HSA amount for the current year, provided the Participant is eligible on December 1 of the current year and remains eligible and enrolled through December 31 of the following year. If eligibility is lost prior to December 31 of the following year, the excess contributions must be returned (upon participant request) by the tax filing deadline (April 1) to avoid being treated as income and also have a penalty applied.

Participants whose spouse also has his or her own HSA can contribute up to the family limit as long as one of them has family coverage. The limit is split between the Participant and Spouse. However, if the Participant and Spouse are each enrolled in single coverage, they are each limited to the contribution limit for single coverage.

Eligible expenses incurred by or for a tax dependent of the primary participant may be reimbursed by the primary participant's HSA—even if the tax dependent is not in the HealthFlex HSA Plan.

Participants are responsible for complying with IRS contribution limits and all other applicable IRS regulations associated with an HSA.

### **HSA Tax Reporting**

HSA contributions are not taxable income but must be reported on IRS *Form W-2*. Both employer and employee pre-tax HSA contributions must be reported in Box 12, Code W "Employer contributions" of the *W-2*.

### **HSA Reimbursements**

The HSA allows reimbursement for eligible medical expenses. To be an eligible expense, a Participant cannot otherwise be reimbursed for the expense by the Plan or through other insurance or similar group health coverage; and he or she cannot claim the expense as an itemized deduction on an individual income tax return. In other words, the expense must be out-of-pocket to the Participant, and he or she cannot "double dip." Many out-of-pocket health care expenses, such as Co-payments, Co-insurance amounts, Deductibles and out-of-network charges, are reimbursable. In addition, medical expenses described in §213(d) of the Code are eligible for reimbursement from the HSA.

HSAs may also be used for non-eligible expenses; however, the amount used for non-eligible expense is treated as taxable income and subject to a penalty if the Participant is under age 65.

### **Carryover of Accounts**

If any balance remains in the HSA for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall be carried over to reimburse the Participant for eligible medical expenses incurred during a subsequent Plan Year.

### **Termination of HSA Participation**

If a Participant is no longer eligible to participate in an HSA plan (e.g., elected a non-HSA plan, retired or terminated, or enrolled in Medicare) and a balance remains in his or her HSA, the funds are available for use until exhausted. The HSA balance is never lost or forfeited; it remains with the Participant. Additional charges may apply for terminated participants who choose to keep their HSA accounts with Health Equity.





## **COORDINATION OF BENEFITS—WHEN YOU HAVE COVERAGE UNDER ANOTHER PLAN**

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.

### **Coordination of Benefits for Medical and Behavioral Health**

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. 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.

- 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.

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.

If none of the above rules apply, then the coverage that has been in effect the longest is 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 with respect to the other plan.

#### **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.

#### **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 and Medicare should pay primary, 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.

#### **WHEN HEALTHFLEX PAYS SECONDARY TO MEDICARE**

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 and/or their Dependents on Continuation Coverage who are eligible for Medicare.
- An Employee or Participant who is not actively working and 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 and covered by the Plan Sponsor or employer's MSP-Small Employer Exception policy (upon MSP Small Employer Exception approval).
- 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.

#### **No Coordination of Benefits for Pharmacy Benefits**

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 OptumRx 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.

#### **Coordination of Benefits for Dental Benefits**

This section applies if you or any one of your Dependents is covered under more than one dental plan and determines how dental benefits payable from all such plans will be coordinated. You should file all Claims with each plan, including this Plan.

#### **ORDER OF BENEFIT DETERMINATION RULES**

A Paying Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Paying Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Paying Plan that covers you as an enrollee or an employee shall be the Primary Plan, and the Paying Plan that covers you as a Dependent shall be the Secondary Plan. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Paying Plan that covers the parent as an enrollee or employee whose birthday falls first in the calendar year.
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

- first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage, and the Paying Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
- then, the Paying Plan of the parent with custody of the child;
- then, the Paying Plan of the Spouse of the parent with custody of the child;
- then, the Paying Plan of the parent not having custody of the child; and
- finally, the Paying Plan of the Spouse of the parent not having custody of the child.
- The Paying Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan, and the Paying Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Paying Plan does not have a similar provision and, as a result, the Paying Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Paying Plan that covers you under a right of continuation that is provided by federal or state law shall be the Secondary Plan, and the Paying Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Paying Plan does not have a similar provision and, as a result, the Paying Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

If none of the above rules determines the order of benefits, the Paying Plan that has covered you for the longer period of time shall be the Primary Plan.

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

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

As each Claim is submitted, the Plan will determine the following:

- The Plan's obligation to provide services and supplies.
- Whether there are any unpaid Allowable Expenses during the Claims Determination Period.

Examples of expenses or services that are *not* Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Paying Plans is not an Allowable Expense.
- If you are covered by two or more Paying Plans that provide coverage for services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Paying Plan that provides coverage for services or supplies on the basis of reasonable and customary fees and one Paying Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher Co-payment amount, higher Co-insurance percentage, a Deductible and/or a penalty) because you did not comply with Paying Plan provisions or because you did not use a preferred, Participating or network provider, the amount of the reduction is not an Allowable Expense. Such Paying Plan provisions include second surgical opinions and precertification of admissions or services.

**RECOVERY OF EXCESS BENEFITS**

If this Plan pays charges for benefits that should have been paid by the Primary Plan, this Plan will have the right to recover such payments.

This Plan will have the right to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, health care plan or other organization. If CIGNA requests, you shall execute and deliver to CIGNA such instruments and documents as CIGNA determines are necessary to secure the right of payment recovery.

**No Coordination of Benefits for Vision Benefits**

If you or your Dependents have Vision coverage through HealthFlex and through another group health plan or other insurance, VSP *will not* coordinate its payment for vision related expenses with those of the other group health plan or insurance. This means that HealthFlex will provide the coverage described in the Vision Benefits section above regardless of your other vision coverage.



## **CLAIMS AND APPEALS PROCEDURES**

## CLAIMS AND APPEALS PROCEDURES

If you disagree with the determination of one of the Claims Administrators prior to or while receiving Services, you may appeal that decision by contacting the appropriate Claims Administrator as described in the applicable section below.

If you disagree with the determination of Wespath regarding your eligibility for coverage under HealthFlex, you may appeal that decision by contacting Wespath as described in the [HealthFlex Summary Plan Description](#).

### LIMITATIONS OF ACTIONS

You cannot bring any legal action against the Plan, Wespath, any of the Claims Administrators, or Plan Sponsors of any kind until you have exhausted these Claims and Appeals procedures. If you want to bring a legal action against the Plan, Wespath, a Claims Administrator, or Plan Sponsor, you must do so within 12 months from the date of the final appeal denial sent by the Appeals Committee or Claims Administrator, as applicable, or you lose any rights to bring such an action.

### Medical and Behavioral Health Claims and Appeals

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 requirements under the PPACA and applicable regulations issued by the Department of Health and Human Services regarding claims, appeals and external reviews.

#### Claims

In order to obtain your benefits under HealthFlex, it is necessary for a Claim to be filed with the applicable Claim Administrator. To file a Claim, usually all you will have to do is show your identification card to your hospital, physician, or other provider, and they will file your Claim for you. Once the Claim Administrator receives your Claim from the provider, it will be processed, and the benefit payment will usually be sent directly to the provider. You will receive a statement telling you how your benefits were calculated.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from an out-of-network provider other than a hospital or physician. To file your own Claim, you may contact your Claims Administrator at the number on the back of your health care ID card or access the Claims Administrator’s web portal through Wespath’s Benefits Access Portal (log in at [benefitsaccess.org](http://benefitsaccess.org), click the **Health** menu, and then the link under **Medical and Behavioral Health**).

A Claim for benefits must be filed with the Claim Administrator in a format required by the Claim Administrator within one year after the later of the date the events giving rise to the Claim occurred and the date you knew or should have known of the facts or events giving rise to the Claim. If you do not meet this deadline, you will be deemed to have waived your right to make a Claim or to pursue any other remedy, including filing a lawsuit.



### Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below:

1. **Clinical Claims of a Urgent Nature** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of the your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to the Claim 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 Claim Administrator may request in connection with services rendered to you.

<b>Clinical Claims of an Urgent Nature*</b>	
<b>Type of Notice or Extension Timing</b>	<b>Type of Notice or Extension Timing</b>
If your Claim is incomplete, the Claim Administrator must notify you within:	<b>24 hours**</b>
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	<b>48 hours after receiving notice</b>
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	<b>72 hours</b>
after receiving the completed Claim (if the initial Claim is incomplete), within:	<b>48 hours</b>

\*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your identification card as soon as possible to submit an Urgent Care Clinical Claim.

\*\*Notification may be oral unless the claimant requests written notification.

<b>Pre-Service Claims</b>	
<b>Type of Notice or Extension Timing</b>	<b>Type of Notice or Extension Timing</b>
If your Claim is filed improperly, the Claim Administrator must notify you within:	<b>5 days*</b>
If your Claim is incomplete, the Claim Administrator must notify you within:	<b>15 days</b>
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	<b>45 days after receiving notice</b>
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete, within:	<b>15 days**</b>
after receiving the completed Claim (if the initial Claim is incomplete), within:	<b>30 days</b>
if you require post-stabilization care after an Emergency within:	<b>the time appropriate to the circumstance not to exceed one hour after the time of request</b>

\*Notification may be oral unless the claimant requests written notification.

\*\*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

<b>Post-Service Claims</b>	
<b>Type of Notice or Extension Timing</b>	<b>Type of Notice or Extension Timing</b>
If your Claim is incomplete, the Claim Administrator must notify you within:	<b>30 days</b>
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	<b>45 days after receiving notice</b>
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete, within:	<b>30 days*</b>
after receiving the completed Claim (if the initial Claim is incomplete), within:	<b>45 days</b>

\*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

<b>Concurrent Care</b>
<p><i>If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Claim Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.</i></p> <p><i>Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Claim Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Non-urgent concurrent care decisions will be decided consistent with the timelines above for Pre-Service Claims.</i></p>

### **Appeals**

You may file an appeal of an Adverse Benefit Determination by writing to:

Quantum Health - Appeals Department  
5240 Blazer Parkway  
Dublin, OH 43017  
Fax: 1-877-498-3681  
Access online through [BenefitsAccess.org](https://BenefitsAccess.org)

There is one level of internal appeal available to you. If you would like to appeal, you must submit the appeal to the Claims Administrator within 180 days after you receive notice of an Adverse Benefit Determination. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the appeal process.

During the appeal process, the Claims Administrator will:

- provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- permit you to submit written comments, documents, records and other information relating to the claim;
- provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial Claim determination;
- provide a review that does not afford deference to the initial Claim determination and that is conducted by a person other than the person who conducted the initial Claim determination (or a subordinate of that person);
- if the decision is based on a medical judgement, consult with a health care professional with experience in the appropriate field;
- provide you, upon request, with the identity of those medical experts whose advice was obtained in connection with the Claim; and
- ensure that any health care professional consulted during the review is someone other than the person consulted in the initial Claim determination (or a subordinate of that person).

The Claim Administrator will make a decision of an appeal as follows:

- *Clinical Claims of an Urgent Nature*: In the same timeframe as described above for initial Clinical Claims of an Urgent Nature.
- *Pre-Service Claim*: As soon as practical, but in no event more than 30 calendar days after receipt of all required information.
- *Post-Service Claim*: As soon as practical, but in no event more than 60 calendar days after receipt of all required information.
- *Concurrent Care Claim*: As soon as practical, but in no event more than 72 hours for if it is an Urgent Care Claim or a reduction/termination of previously approved benefits or 30 calendar days where the appeal is related to a request to extend a non-urgent course of treatment.

The above deadlines may not be extended, unless you agree to such extension.

### ***Notice of Adverse Benefit Determinations***

If your Claim or appeal is denied in whole or in part, the Claim Administrator will send you a Notice of the denial that includes:

- the specific reasons for such denial;
- a reference to the specific provisions of the Plan on which the decision is based;
- for a denial of an initial Claim, a description of any additional information necessary for you to perfect the Claim, and an explanation of why such material or information is necessary;
- a description of the Plan's appeal procedures and the time limits applicable to those procedures;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the your Claim for benefits;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the decision and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
- if the decision is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of a determination of an Clinical Claim of Urgent Nature, a description of the expedited review procedure applicable to such Claims will also be included. An Clinical Claim of Urgent Nature decision may be provided to you orally.

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](http://www.hhs.gov)) or call the phone number on the back of your ID Card for contact information.

### **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 are 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 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.

***Final Treatment Decision is Yours***

The final decision regarding your course of treatment is solely your responsibility, and the Claims Administrator will not interfere with your relationship with any Provider even if the Plan does not pay for the treatment. However, the Claims Administrator has established the appeal process for the specific purpose of assisting you in determining the course of treatment that will maximize your Plan benefits described in this Benefit Booklet.

## **Prescription Drug Claims and Appeals**

Claims and appeals for prescription drugs will be handled as described above for Medical/Behavioral Health Claims, except that Claims and appeals for prescription drugs should be sent to:

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

## **Dental Claims and Appeals**

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from an out-of-network dental provider. To file your own Claim, you may contact Cigna at (800) 244-6224 or access Cigna's website through Wespath's Benefits Access Portal (log in at [benefitsaccess.org](https://benefitsaccess.org), click the **Health** menu, and then the link under **Dental**).

To initiate an appeal of a Claim for dental benefits that has been denied by Cigna, you must submit a request for an appeal to Cigna in writing at the address below:

Cigna Dental Appeals  
PO Box 188044  
Chattanooga TN 37422-8044  
(800) 244-6224

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal with Cigna by telephone. Call or write to Cigna at the number listed above.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

Cigna will acknowledge in writing that we have received your appeal within five working days after the date we receive your appeal for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

#### **Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the Independent Review Organization. In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

The Independent Review Program is a voluntary program arranged by Cigna.

**Notice of Benefit Determination on Appeal**

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the denial decision; reference to the specific plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; and a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to bring action in state or federal court ; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

**Relevant Information**

Relevant information is any document, record or other information which:

- was relied upon in making the benefit determination;
- was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information
- demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**Vision Claims and Appeals**

You have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at [www.vsp.com](http://www.vsp.com). Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals of denied Claims, in writing to:

**VSP**

**3333 Quality Drive,  
Rancho Cordova, CA 95670-7985  
1-800-877-7195.**

VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

**Vision Claim Payments and Denials**

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the Claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

### **Health and Reimbursement Account Claims and Appeals**

In order to be considered for appeal the original claim that was submitted must have been submitted within eligible plan dates and deadlines. Additionally, the request must be received within 180 days of the date of the original denial. Appeals must be sent to:

**Health Equity Appeal Board**  
**PO Box 14034**  
**Lexington, KY 40512 Or Fax To: 1-877-220-3248**

Participants should include:

- Written comments
- Medical records
- Letter (s) of medical necessity from their health care provider
- Any other information they feel will support a decision reversal

Claims and appeals for reimbursements from an HRA will be subject to the same Claims and appeals procedures as described above for Medical/Behavioral Health Claims, except that HealthEquity is the applicable Claims Administrator.





## 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.

### ADVERSE BENEFIT DETERMINATION

A determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage (i.e., a retroactive cancellation of coverage) is also an Adverse Benefit Determination unless it is due to failure to timely pay required premiums/contributions.

### 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 or Allowed Amount means the amount that the Plan will pay for Prescription Drugs based upon pricing at a Participating Retail Pharmacy. It may also refer to the amount that a Claims Administrator has negotiated for a service with an In-network provider.

### ALLOWABLE EXPENSE

A necessary, reasonable and customary service or expense—including Deductibles, Co-insurance or Co-payments—that is covered in full or in part by the Plan/Paying Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

### 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.

#### **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.

**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 DETERMINATION PERIOD**

A calendar year, but does not include any part of a year during which you are not covered under HealthFlex or any date before this section or any similar provision takes effect.

**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

Any pastoral counselor or 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.

**CLOSED PANEL PLAN**

A Paying Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**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.

**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 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 not self-supporting due to a physical or mental disability, provided the disability existed before the child attained the age of 26.

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).

In addition, for purposes of the Health Care FSA, the term Dependent includes a Participant's child who has not attained age 27 as of the end of the Plan Year consistent with the tax exclusions for coverage and reimbursements under §105 and §106 of the Code.

For the purposes of the Dependent Care FSA, the term Dependent means an individual who is:

- a dependent (as defined in §152 of the Code) of a Participant: (1) who is physically or mentally incapable of caring for himself or herself, or (2) who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code; or
- a dependent (as defined in §152 of the Code) of the Spouse of a Participant, who is physically or mentally incapable of caring for himself or herself.

For 2020 and 2021 only, “age of 14” shall be substituted for “age of 13” in the first bullet above to the extent allowed by Section 214(d) of the Taxpayer Certainty and Disaster Relief Act of 2020 within the Consolidated Appropriations Act, 2021.

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 Out-of-Network Providers, Eligible Expenses are determined at the Claims Administrator’s discretion by either (1) paying 400% of the base Medicare reimbursement rate for the service at issue in the geographic area in which the service is received (except that, for services received in Illinois, the Plan will pay 100% of the base Medicare reimbursement rate) ; or (2) applying the negotiated rates agreed to by the Out-of-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors. When Covered Services are received from Out-of-Network Providers, 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 amount under the Plan.

**New, special rules for certain out-of-network providers:** As required by applicable law, in-network cost sharing rules may apply to determine your coinsurance for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. Your coinsurance amount will be determined based on the applicable “qualifying payment amount” (QPA), which is the median of the Claim Administrator’s in-network rates for the applicable service and geographic region, rather than the Eligible Expense amount described above. The providers are prohibited from balance billing you for more than your coinsurance based on the QPA for these services. For more information, please contact the Claims Administrator.

#### **ELIGIBLE PERSON**

The term Eligible Person means an employee of a Plan Sponsor 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.

#### **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 the C2000 and C3000 Benefit Options under the Plan, which are designed to drive participants' behavior toward informed medical decision-making and typically carry a 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/Benefits Access website ([BenefitsAccess.org](https://BenefitsAccess.org)), or at [OptumRx.com](https://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 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 In or Out-of-Network, 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.

**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 Dental or Vision Services.

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.

**PAYING PLAN**

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, except
- Medicaid and Medicare supplement policies.
- Medical or dental benefits coverage of group, group-type, and individual automobile contracts.

Each Paying Plan or part of a Paying Plan that has the right to coordinate benefits will be considered a separate Paying Plan.

**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 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.

**PRIMARY PLAN**

For purposes of Coordination of Benefits, the Primary Plan is the Paying Plan that determines and provides or pays benefits without taking into consideration the existence of any other Paying Plan.

**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.

**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.

**REASONABLE CASH VALUE**

An amount which a duly licensed provider of dental care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

**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.

**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.

**SECONDARY PLAN**

For purposes of Coordination of Benefits, a Secondary Plan is a Paying Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided by or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**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.

**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**

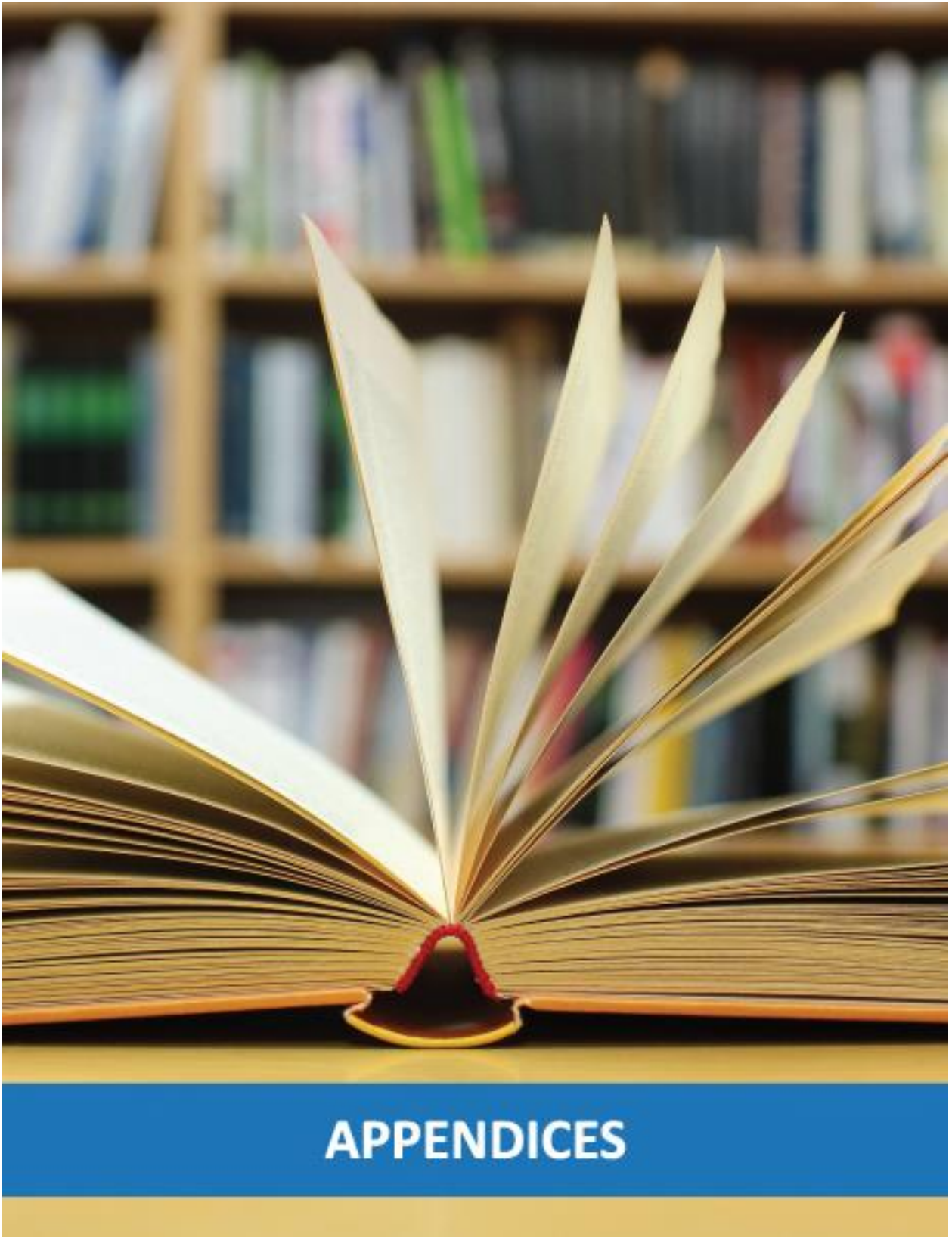
An Urgent Care Center is a facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**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.



# Appendix A

## 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 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.

**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.

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