PEDIGREE OVENS INC.

EMPLOYEE HEALTH PLAN

BENEFITS SCHEDULE

TABLE OF CONTENTS

PEDIGREE OVENS INC.

BENEFITS DESCRIPTION

ARTICLE I
DEFINITIONS

This Article defines the terms used in this Plan. The inclusion of a term in this document does not imply that a service is a Covered Service.

"**Allowable Amount**" Maximum amount on which payment is based for Covered Services.

"**Adverse Benefit Determination**" Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

"**Ambulance**" A specially designed or equipped vehicle used only for transporting the critically ill or injured to a health care facility. The Ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

"**Appeal**" It is a review of an adverse benefit determination by the Third-Party Administrator, as required under this Plan's claims and internal Appeals procedures.

"**Applied Behavioral Analysis**" It is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

"**Assisted Living**" A combination of housing, personalized supportive services, and health care designed to meet the needs—both scheduled and unscheduled—of those who need help with activities of daily living.

"**Authorized Representative**" A person designated by the Claimant or this Plan to act on behalf of the Claimant.

"**Behavioral Disorder Intensive Outpatient Treatment"** It is treatment in the outpatient hospital setting of a behavioral disorder by a licensed person or group of persons working under the direction or supervision of a physician to provide individual, group, family or conjoint psychotherapy, counseling, psychoanalysis or psychological testing and assessment.

"**Behavioral Health Care**" Behavioral Health Care are the continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders. Behavioral Health, as a discipline, refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrist, psychologists, neurologists, and physicians.

It is a treatment that is or will be provided for the diagnosis, evaluation, and treatment of Behavioral Disorders which shall include all of the general criteria for medical necessity.

"**Chelation Therapy**" It is a chemical process in which a synthetic solution - EDTA (ethylenediaminetetraacetic acid) - is injected into the bloodstream to remove heavy metals and/or minerals from the body.

"Chemical Dependency" It is a treatment that is or will be provided for the diagnosis, evaluation, and treatment of Chemical Dependency. Treatment shall include all of the general criteria for medical necessity.

"**CHIP/CHIPRA**" The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to as such act, provision or section may be amended from time to time, including the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"**Chiropractic Care**" It is the skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

"**Claim**" It is a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

"**Claimant**" Is a Covered Individual (or the Authorized Representative of the Covered Individual) who is entitled to and makes a Claim for benefits under the Plan.

"**Claims Administrator**" The term "Claims Administrator" means a person or persons, or entity or entities, appointed by the Plan Administrator to serve as the Claims Administrator for the Plan. The Claims Administrator's responsibilities include making the initial determination of the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the

agreement between the Plan Administrator and the Claims Administrator. The Claims Administrator is the TPA.

"**COBRA**" The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" The Internal Revenue Code of 1986, as amended.

"**Co-insurance**" It is a Covered Individual's share of Covered Services and supplies, not counting the deductible (if applicable). It is usually a percentage of the Allowable Amount.

"**Complications of Pregnancy**" Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, *but shall not include* false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and Non-elective Caesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

"**Concurrent Claim**" A claim that requires Pre-Authorization under this Plan that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claims: 1) where reconsideration by this Plan results in a reduction or termination of coverage for a previously approved benefit, and 2) where an extension is requested by the Claimant for coverage beyond the initially approved benefit.

"**Co-payment**" The amount a Covered Individual must pay for certain Covered Services. Covered Services subject to a Co-Payment and the amounts are listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule, as applicable. A Co-Payment is a flat dollar amount. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Co-Payment directly to the Health Care Provider. In other instances, the Covered Individual will be billed by the Health Care Provider.

"**Cosmetic Surgery**" Any Surgery, service, Drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an injury.

"**Cost-Sharing Amounts**" The dollar amount a Covered Individual is responsible for paying when Covered Services are received from a Health Care Provider. Cost-Sharing Amounts include Cost-Sharing Percentages, Co-Payments, and Deductibles where applicable. Cost-Sharing Amounts are identified in the applicable Medical Benefits Schedule or Pharmacy Benefits Schedule. Health Care Providers may bill a Covered

Individual directly or request payment of Cost-Sharing Amounts at the time Covered Services are provided. Cost-Sharing Amounts for Covered Services provided by In-Network Health Care Providers count toward the Out-of-Pocket Maximum. Cost-Sharing Amounts for Covered Services provided by unapproved Out-of-Network Health Care Providers do not count toward the Out-of-Pocket Maximum, and they continue after the Out-of-Pocket Maximum has been met.

"**Cost-Sharing Percentage**" The charge a Covered Individual must pay for certain Covered Services after any applicable Deductibles and Co-Payments have been paid. The Cost-Sharing Percentage is a percentage of the Covered Charge, not the actual billed charge. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Cost-Sharing Percentage directly to the Health Care Provider. In other instances, the Covered Individual will be billed by the Health Care Provider. These arrangements are between the Covered Individual and the Health Care Provider.

"**Coverage Year**" It is the time period, not to exceed twelve (12) months, from the effective date of this Plan to the anniversary date. All subsequent Coverage Years shall begin on the anniversary date and consist of a period of not more than twelve (12) months. This Plan's Coverage Year is the 1st day of August through the 31st day of July.

"**Covered Charge**" It is the Reasonable, and Maximum Allowable Charge, or portion of the charge, by Health Care Providers for Covered Services eligible for payment under this Plan. It is the established negotiated rate for In-Network charges, and it is the Plan's Maximum Allowable Charge for approved Out of Network services

"**Covered Dependent**" It is a Dependent who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated.

"**Covered Employee**" It is an employee who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated.

"**Covered Individual**" It is a Covered Employee or Covered Dependent who is participating under this Plan in accordance with the Eligibility Article and whose coverage has not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Plan.

"**Covered Service(s)**" Are those Medically Necessary, Reasonable services, drugs, supplies and equipment identified as Covered Charges in the Benefits Schedule subject to the Plan's Maximum Allowable Charge. In determining whether an expense is a Covered Service all plan definitions, provisions, limitations and exclusions will be considered for which coverage benefits are available under the Plan per the Benefits Schedule.

"**Creditable Coverage**" Coverage required by law to be counted for purposes of offsetting a preexisting condition period, and includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO

Covered Individual, an individual health insurance policy, Medicaid, Medicare, or public plans. Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable Coverage does not include coverage that was in place before a significant break of coverage of sixty-three (63) days or more.

"**Custodial Care**" Care (including Room and Board needed to provide that care) that is given principally to personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed, assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

"**Day Services**" Services provided in a day care center which is a non-residential Day facility that supports the health, nutritional, social, and daily living needs in professionally staffed, group settings.

"**Deductible**" The aggregate amount for certain Covered Services that is a Covered Individual's responsibility each Calendar Year before this Plan will begin to pay for most Covered Services under the terms of the Plan. Co-insurance, Co-Payments and Penalties do not apply to the Deductible.

"**Dental Care Services**" The professionally recognized dental services, supplies, or appliances which are provided to a Covered Individual by a physician or provider, when acting within the scope of his license, who is a Doctor of Dentistry (DDS or DMD degree) and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental care services include, but are not limited to, cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium process of the maxilla and the mandible.

"**Dentist**" It is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

"**Dependent**" A dependent of the Covered Employee who may qualify for coverage under this Plan in accordance with the following requirements: a spouse, a Covered Employee's child who is a resident of the United States and is either less than twenty-six (26) years of age as of the close of the tax year, or regardless of age, is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Covered Employee for support and maintenance. The child must have been covered under this Plan immediately prior to reaching the age limitation. For the child to be a Dependent, the Plan Administrator must be notified within thirty (30) days after the date coverage under this Plan would normally end. Proof of incapacity may be requested from time to time. Moreover, the child must be the Employee's natural child, the Employee's stepchild, the Employee's legally adopted child, a child placed in the Covered Employee's physical custody whom the Covered Employee intends to adopt, the Employee's foster child, a child for whom the Covered Employee and/or the Spouse has been named Legal Guardian, or the Covered Employee's child or children for whom the Covered Employee has a QMCSO. Individuals

specifically excluded from the Plan's definition of a Dependent are any person on active military duty, any person covered under this Plan as a Covered Employee, and any person covered as a Dependent by another Covered Employee.

"Direct Contract" A contract between ACTIN and a provider rather than a contract between a provider and First Health Group Corp (First Health) that ACTIN accesses through its contract with First Health.

"**Durable Medical Equipment**" Equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally is not useful to a person in the absence of an illness or injury, and 4) is appropriate for use in the home.

"**Educational**" The primary purpose of a service or supply is to provide the Covered Individual with any of the following: training in the activities of daily living, instructions in scholastic skills such as reading and writing, preparation for an occupation or treatment for learning disabilities.

"**Effective Date**" The date the Covered Individual's coverage begins.

"**Eligible Employee**" An Employee or former Employee who meets the eligibility criteria for this Plan as described in the Eligibility Article and who has not ceased to meet the eligibility criteria.

"**Emergency**" The term "emergency" has a specific meaning. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) that would lead a prudent layperson who possesses average knowledge of health and medicine to believe that the absence of immediate medical attention could result in:

- placing the health of the individual (and in the case of a pregnant woman, her health or that of her unborn child) in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- With respect to a pregnant woman who is having contractions that:
  - there is inadequate time to affect a safe transfer to another hospital before delivery; or
  - A transfer may pose a threat to the health or safety of the woman or the unborn child.

"**Emergency Care**" Emergency care means Covered Services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an

average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

"**Employee**" A common-law employee of the Employer, as determined solely from the employment records of the Employer. If an individual who provides or provided services to the Employer is classified by the Employer as an independent contractor, such individual shall not be treated as an Employee for purposes of this Plan.

"**Employer**" Pedigree Ovens Inc. or affiliated entity that has been recognized by Pedigree Ovens Inc. as eligible to participate and has agreed to participate in this Plan.

"End Stage Renal Disease" Permanent kidney failure requiring a regular course of long-term dialysis or a kidney transplant to maintain life.

"**ERISA"** The Employee Retirement Income Security Act of 1974 as amended.

"**Environmental Sensitivity**" The inpatient or outpatient treatment of allergic symptoms by controlled environment; or sanitizing the surroundings, removal of toxic materials; or use of special non-organic, non-repetitive diet techniques.

"**Experimental or Investigational (Experimental)**" Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services and treatments include services, supplies, care, procedures, treatments, or courses of treatment which do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered, are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies, all phases of clinical trials shall be considered Experimental (except that expenses for otherwise Covered Services that are Incurred by a Covered Individual participating in a clinical trial will be covered to the extent legally required). A drug, device or medical treatment or procedure is Experimental if 1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, 2) reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, and efficacy as compared with the standard means of treatment or diagnosis, or if reliable evidence shows that the

consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its efficacy as compared with the standard means of treatment or diagnosis. "Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure. The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"**Extended Care Expense**" These are the services and supplies provided by a skilled nursing facility, a home health agency or a hospice.

"**Family Out-of-Pocket Maximum**" The Out-of-Pocket Maximum amount that if satisfied by the Family Covered Individuals, in aggregate, in a Coverage Year will cause each Family Covered Individual to be treated as having met the Out-of-Pocket for the remainder of that Coverage Year.

"**FMLA**" This is The Family and Medical Leave Act of 1993, as amended.

"**Formulary**" This is a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

"**Genetic Information**" This is the Information about the genetic tests of an individual or his family of Covered Individuals, and information about the manifestations of disease or disorder in family Covered Individuals of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

"**GINA**" The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

"**Health Care Provider**" These are the Institutional Health Care Providers or professional Health Care Providers providing Covered Services to Covered Individuals. Each Health Care Provider must be licensed, registered, or certified by the appropriate state agency where the Covered Services are performed. Where there is no appropriate state agency, the Health Care Provider must be registered or certified by the appropriate professional body. Health Care Providers include Advanced Practice Registered Nurses (including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, and Nurse Practitioner, Ambulatory Surgical Facility(a facility with an organized staff of Physicians that has permanent facilities and equipment for the

primary purpose of performing surgical procedures on an outpatient basis, provides treatment by or under the direct supervision of a Physician or other Health Care Provider, does not provide inpatient accommodations, and is not a facility used as an office or clinic for the private practice of a Physician or Dentist), Audiologist, Chiropractor, Dentist including DDS, Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine, Durable Medical Equipment Health Care Provider, Home Health Agency, Hospice, Hospital, Licensed Practical Nurse (LPN), Licensed Registered Dietician, Occupational Therapist, Optometrist- a Doctor of Optometry (DO), Physical Therapist, Physician-(MD or DO), Physician Assistant-an individual licensed by the medical examining board to provide medical care with Physician supervision and direction, Podiatrists, Psychiatrist, Psychologist, Radiation Therapist, Registered Nurse (RN), Respiratory Therapist, Skilled Nursing Facility, Social Worker, Speech Therapist, Speech Pathologist, Urgent Care Facility.

"**Health Care Reform**" The provisions of the Patient Protection and Affordable Health Care Act (PPACA0, as amended by the Health Care and Education Reconciliation Act (Reconciliation Act), applicable to major medical coverage to the fullest extent allowed by law.

"**Health Care Services**" The provision by Health Care Providers of all medical treatment, Disposable Supplies, Durable Medical Equipment, Orthotics, or Prosthetics as defined in this Plan.

"**HIPAA**" This is The Health Insurance Portability and Accountability Act of 1996, as amended.

"**Home Health Care Agency**" An organization that meets all of these conditions: 1) its main function is to provide Home Health Care Services and Supplies; 2) it is federally certified as a Home Health Care Agency; and 3) it is licensed by the state in which it is located, if licensing is required.

"**Home Health Care Plan**" Must meet these conditions: 1) it must be a written plan made by the patient's treating Physician which is reviewed at least every thirty (30) days; 2) it must state the diagnosis; 3) it must certify that the Home Health Care is in place of Hospital confinement; 4) it must specify the type and extent of Home Health Care required for the treatment of the patient.

"**Home Health Care Services and Supplies**" Include part-time or intermittent nursing care by or under the supervision of a registered nurse (RN), part-time or intermittent home health-aide services provided through a Home Health Care Agency, physical, occupational and speech therapy, medical supplies, and laboratory services by or on behalf of the Hospital.

"**Hospice Agency**" An organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located if licensing is required.

"**Hospice Care Plan**" This is the plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

"**Hospice Care Services and Supplies**" Are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

"**Hospice Unit**" A facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

"**Hospital**" A short-term acute care facility which:

- Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare;

- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians for compensation from its patients;

- Has organized departments of medicine and major surgery and maintains clinical records on all patients;

- Provides 24-hour nursing services by or under the supervision of a registered nurse;

- Has a hospital utilization review plan; and

- Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

"**Hospital Admission**" This is the period between entry into a hospital as a bed patient and the time of discharge. If a patient is admitted to and discharged from a hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time confined in the hospital, the admission shall be considered a hospital admission. *Bed patient* means confinement in a bed accommodation located in a portion of a hospital which is designed, staffed and operated to provide acute, short-term hospital care on a 24-hour basis; the term does not include confinement in a portion of the hospital designed, staffed and operated to provide long-term institutional care on a residential basis. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

"**Hospital Discharge**" Discharge from the hospital is the point at which the patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or to a nursing home.

"**Hypnotherapy**" It is a type of therapy used to create subconscious change in a patient in the form of new responses, thoughts, attitudes, behaviors or feelings. It is undertaken with a subject in hypnosis.

"**Illegal Acts**" Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

"**Illness**" Is a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

"**Incurred**" A Covered Charge is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"**Infertility**" It is the inability to produce offspring.

"**Injury**" It is an accidental physical injury to the body caused by unexpected external means.

"**In-Network**" The Actin Care Groups network of Health Care Providers as indicated on the Covered Individual's Covered Individual Card and on the Members tab, Provider Lookup, of the ACTIN website, www.actincare.com.

"**Intensive Care Unit**" This is a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has facilities for special nursing care not available in regular rooms and wards of the Hospital, special life-saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (RN) in continuous and constant attendance twenty-four hours a day.

"**Late Enrollee**" A Covered Individual who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

"**Legal Guardian**" A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

"**Long Term Acute Care Facility**" A long term acute care facility is a specialty-care hospital designed for patients with serious medical problems that require intense, special treatment for an extended period of time—usually 20 to 30 days.

"**Maximum Amount and/or Maximum Allowable Charge**" The benefit payable for a specific Covered Service or benefit under the Plan subject to Network Adequacy. Maximum Allowable Charge(s) will be the least of: 1) the Usual and Customary Rate amount; 2) the allowable charge specified under the terms of the Plan; 3) the negotiated rate established in a contractual arrangement with a Health Care Provider; or 4) the actual billed charges for the Covered Services. The Plan will reimburse the actual charge billed if it is less than the Usual and Customary Rate amount. The Plan has the discretionary authority to decide if a charge is a Usual and Customary Rate and for a Medically Necessary and Reasonable service.

"**Medical Benefits**" Benefits available under this Plan.

"**Medical Benefits Schedule**" The schedule of Covered Charges listed in the Summary of Benefits Article of the Plan summarizing the Medical Benefits available under this Plan.

"**Medical Care Facility**" This is a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

"Medical Eye Examination" This is a medically necessary comprehensive examination for the diagnosis and treatment of diseases and conditions of the eye performed by a physician/surgeon. This exam evaluates the reasons for the symptoms and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases.

"**Medical Necessity**" It is a treatment that is or will be provided for the diagnosis, evaluation, and treatment of an illness or injury and that is:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's illness or injury.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting, or level of service that can safely be provided to the patient, and which cannot be omitted consistent with recognized professional standards of care; for a

hospitalization, it means that safe and adequate care could not be obtained in a less comprehensive setting or level of care.

- Cost-effective compared to alternative interventions, including no intervention.

- Not experimental/investigational: The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to the definition in this Plan.

- Not primarily for the convenience of the patient, the patient's family, or the provider.

- Be reasonably expected to improve the individual's condition and prevent further relapse or regression.

- Be provided in the least restrictive level of care that is appropriate to meet the needs of the Covered Individual.

The fact that a provider may prescribe, order, recommend, or approve any care or treatment does not, of itself, make any care or treatment Medically Necessary or a covered expense and does not guarantee payment.

MCM determines Medical Necessity by Interqual criteria and physician review. Retrospective review of the Medical Necessity of services, including urgent care, is determined by physician review.

If an in-network or approved out-of-network physician, nurse practitioner or physician's assistant recommends that a Covered Individual go to Urgent Care and the Covered Individual is seen at an in-network urgent care center, by definition that visit is Medically Necessary. If a Covered Individual is seen at an in-network urgent care center that upon retrospective review was not Medically Necessary, that visit is covered at 70% with the Covered Individual responsible for 30% co-insurance.

"**Medical Social Services**" Services of a type provided by Medical social workers that assess the psychosocial functioning, environmental and support needs of patients and families and intervene as necessary.

"**Medicare**" It is the Health Insurance for Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

"**Membership Identification Card**" An identification card issued in the Covered Employee's name identifying the Covered Individual number of the Covered Employee.

"**Mental Disorder**" Any disease or condition, regardless of whether the cause is organic that is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

"**Michelle's Law**" Pub. L. No. 110-381 (2008).

"**Morbid Obesity**" A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Individual.

"**Named Fiduciary**" Pedigree Ovens Inc.

"**NMHPA**" Is "The Newborns' and Mothers" Health Protection Act.

"**Neonatal Intensive-Care Unit**" It is an intensive-care unit specializing in the care of ill or premature newborn infants.

"**Neurofeedback and Related Techniques**" Neurofeedback, Biofeedback, Neurotherapy or Neurobiofeedback techniques use real-time displays of brain activity - most commonly electroencephalography (EEG), to teach self-regulation of brain function. Typically, sensors are placed on the scalp to measure activity, with measurements displayed using video displays or sound.

"**Non-Emergency**" Any medical condition or circumstance that is not an Emergency, as defined in this Plan.

"Ophthalmologist" An ophthalmologist is a medical or osteopathic doctor who specializes in eye and vision care. Ophthalmologists differ from optometrists and opticians in their levels of training and in what they can diagnose and treat. An ophthalmologist diagnoses and treats all eye diseases, performs eye surgery and prescribes and fits eyeglasses and contact lenses to correct vision problems.

"Optometrist" Optometrists are healthcare professionals who provide primary vision care ranging from sight testing and correction to the diagnosis, treatment, and management of vision changes. An optometrist is not a medical doctor. Optometrists are licensed to practice optometry, which primarily involves performing eye exams and vision tests, prescribing and dispensing corrective lenses, detecting certain eye abnormalities, and prescribing medications for certain eye diseases.

"**Orthotic**" A custom-made brace or external device made for a weak, diseased, or injured body part. An Orthotic can increase, decrease, or eliminate motion or support the weak, diseased, or injured body part.

"**Other Plan**" Shall include, but is not limited to any primary payer besides the Plan, any other group health plan, any other coverage or policy covering the Covered Individual, any first-party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist

coverage, any policy of insurance from any insurance company or guarantor of a responsible party, any policy of insurance from any insurance company or guarantor of a third party, workers' compensation or other liability insurance company, or any other source including crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

"**Out-of-Network**" Health Care Providers that are not in-Network. When Covered Individuals seek Covered Services from Out-of-Network Health Care Providers, they will generally receive a lower level of benefit payment. In addition to Cost-Sharing Amounts, the Covered Individual will be responsible for any charges above the Maximum Allowable Charge when receiving Covered Services from an approved Out-of-Network Health Care Provider. This Plan is under no obligation to pay for Covered Services provided by an unapproved Out of Network Provider except in an emergency. Emergency services provided by any health care provider are Covered Services.

*"***Out-of-Pocket Maximum"** The total Cost-Sharing Amounts for Covered Services provided by In-Network Health Care Providers and approved Out-of-Network Providers that are a Covered Individual's responsibility during a Calendar Year. The Out-of-Pocket Maximums are stated in this Benefits Schedule. When the Out-of-Pocket Maximum is met, this Plan will pay one hundred (100%) percent of the Covered Charges for most Covered Services provided by In-Network Health Care Providers and approved Out-of-Network Providers incurred during the remainder of the Calendar Year. The Out-of-Pocket Maximum renews at the beginning of each Calendar Year. Premiums, the amount a Covered Individual must pay an In-Network specialist for failure to obtain pre-authorization for a specialist visit, the amount a covered individual must pay a provider for failure to obtain pre-authorization for the first outpatient Behavioral Health Care visit, the amount paid to an In-Network Primary Care Provider for primary care services who is not the Employee or Spouse's designated Primary Care Provider, the amount a Covered Individual must pay a hospital facility if admitted to an Emergency Department but not admitted as an inpatient to the hospital, and the amount paid to a facility for obstetric delivery, other than in an emergency, at a hospital other than Alexian Network Hospitals and Loyola University Medical Center do not apply to the Out-of-Pocket Maximum. Penalties do not apply to the Out-of-Pocket Maximum. and charges in excess of applicable plan maximums are not considered with respect to the Out-of-Pocket Maximum. (There is no Rollover from prior year).

"**Outpatient Care and/or Services**" The treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient, or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

"*Outpatient Renal Dialysis*" Medical treatment that is a substitute for the normal functions of the kidneys, including equipment, prescription drugs, supplies and home

dialysis training, when such services are provided in a freestanding dialysis facility or in the home under appropriate supervision.

"Penalty" The amount a Covered Individual must pay an In-Network specialist for failure to obtain pre-authorization for a specialist visit, the amount a Covered Individual must pay a provider of Behavioral Health Care for failure to obtain pre-authorization for the first outpatient visit, the amount paid to an In-Network Primary Care Provider for primary care services who is not the Employee or Spouse's designated Primary Care Provider, the amount a Covered Individual must pay a hospital facility if admitted to an Emergency Department but not admitted as an inpatient to the hospital, and the amount paid to a facility for obstetric delivery, other than in an emergency, at a hospital other than Alexian Network Hospitals and Loyola University Medical Center do not apply to the Out-of-Pocket Maximum. Penalties do not apply to the Out-of-Pocket Maximum.

"**Pervasive Developmental Delay**" This refers to a group of disorders characterized by delays in the development of socialization and communication skills. Parents may note symptoms as early as infancy, although the typical age of onset is before 3 years of age.

"Partial Hospitalization" Is a structured program of outpatient psychiatric services or chemical dependency services as an alternative to inpatient psychiatric or chemical dependency care. This treatment is provided during the day and doesn't require an overnight stay. This Plan covers partial hospitalization services when they are provided through a hospital outpatient department.

"**Physician**" A Doctor of Medicine (MD), Doctor of Osteopathy, Doctor of Podiatry, Doctor of Chiropractic, Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work, Midwife, Occupational Therapist, Doctor of Dental Surgery, Physiotherapist, Psychiatrist, Psychologist, Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

"**Plan**" This Pedigree Ovens Inc. Employee Health Plan, as amended from time to time.

"**Plan Administrator**" The term "Plan Administrator" means the Employer or its designated representative(s). The Plan Administrator retains ultimate authority for this Plan including final Appeals determinations. The Plan Administrator is also the Named Fiduciary for purposes of ERISA.

"**Plan Sponsor**" Pedigree Ovens Inc.

"**Plan Year**" It is the twelve-(12) month period beginning on August 1 of each year.

"**Podiatry**" This is the medical care and treatment of the human foot.

"**Pre-Authorization**" It is the approval by the plan for coverage of specific services, supplies or drugs before they are provided to the member. Pre-Authorization includes verification of eligibility at the time of Pre-Authorization (member must continue to be eligible on the date the service is incurred for the Pre-Authorization to remain valid), verification that the service is a Covered Service and is within Plan limits, and verification that the service is Medically Necessary. In the context of this plan all inpatient services, certain outpatient services, specialist visits and Durable Medical Equipment and supplies require Pre-Authorization.

"**Pregnancy**" Childbirth and conditions associated with Pregnancy, including complications.

"**Prescription Drug**" A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend:" Caution: federal law prohibits dispensing without prescription", insulin for purposes of injection, hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an illness or injury. Prescription Drugs include Brand Name Drugs (patent protected Prescription Drugs), Generic Drugs (a Prescription Drug whose patent has expired and is manufactured by several pharmaceutical companies. FDA A-rated Generic Drugs contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards, and are considered equivalent in all respects to the Brand Name Drug. The Formulary is a list of Prescription Drugs approved by this Plan for use by Covered Individuals, as amended from time to time.

"**Pre-Service Claim**" Any Claim for a benefit under this Plan where receipt of the benefit is specifically conditioned on receiving approval in advance of obtaining the medical care. Benefits under this Plan that are Pre-Service Claims are described in the Utilization Management Programs Article of this Plan document.

"**Preventive Care**" Covered Services rendered primarily for the purpose of health maintenance and not for the treatment of an illness or injury. Preventive Care includes 1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and 4) with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For example, Well-Adult Preventive Care includes (at ages, times, or risk status designated in federal requirements) abdominal aortic aneurysm one-time screening, alcohol–abuse screening and counseling, aspirin use (to prevent cardiovascular disease), blood pressure screening, cholesterol screening, colorectal cancer screening, depression screening, diabetes screening, diet counseling, HIV screening, immunizations, obesity screening and counseling, sexually transmitted infection prevention counseling, syphilis

screening, and tobacco used screening. Well-Woman Preventive Care generally includes (at ages, times, or risk status designated in federal requirements), anemia screening, breast cancer genetic test counseling, breast cancer mammography screening, breastfeeding comprehensive support and counseling, cervical cancer screening, chlamydia infection screening, contraception, domestic and interpersonal violence screening and counseling, folic acid supplements, gestational diabetes screening, gonorrhea screening, hepatitis B screening, HIV screening and counseling, human papillomavirus DNA test, osteoporosis screening, Rh incompatibility screening, sexually transmitted infections counseling, syphilis screening, tobacco use screening and interventions, urinary tract or other infection screening, and well-woman visits. Well-Child Preventive Care generally includes (at ages, times, or risk status designated in federal requirements) autism screening, behavioral assessments, blood pressure screening, cervical dysplasia screening, depression screening, developmental screening, dyslipidemia screening, fluoride chemoprevention supplements, gonorrhea preventive medication, hearing screening, height, weight, and body mass index measurements, hemoglobin or sickle cell screening, HIV screening, hypothyroidism screening, immunizations, iron supplements, lead screening, medical history, obesity screening and counseling, oral health risk assessment, phenylketonuria (PKU) screening, sexually transmitted infection prevention counseling and screening, tuberculin testing and vision screening. Specific details on what services are covered as Preventive Care are provided in detailed schedules available from the Claims Administrator.

"**Primary Care Provider**" A Primary Care Provider can be a Doctor, a Nurse Practitioner or a Physician's Assistant that a person sees for preventive care, for treatment of acute illnesses and for management of common chronic conditions. A Primary Care Practitioner establishes an individual care plan and coordinates care among specialists and other providers.

"**Prosthetic**" Is a fixed or removable device that replaces all or part of an extremity or body part, including such devices as an artificial limb, intraocular lens, or breast prosthesis.

"**QMCSO**" Qualified Medical Child Support Order as determined by the Plan Administrator under procedures established by the Plan Administrator.

"**Reasonable**" In the Plan Administrator's discretion, services, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Health Care Provider. Determination that fees or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of illness or injury necessitating the services and/or charges.

- This determination will consider, but will not be limited to, the findings and assessments of the following entities: 1) The National Medical

Associations, Societies, and organizations, and 2) The Food and Drug Administration.

- To be Reasonable, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures, Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable.

The Plan Administrator retains discretionary authority to determine whether services and fees are Reasonable based upon information presented to the Plan Administrator. A finding of Health Care Provider negligence and/or malpractice is not required for services or fees to be considered not Reasonable. Charges or services are not considered to be Reasonable when they result from Health Care Provider error or facility-acquired conditions deemed avoidable through the use of evidence-based guidelines. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and paid by the Plan, to identify charges and services that are not Reasonable and therefore not eligible for payment by the Plan.

"**Rescind or Rescission**" The process to retroactively terminate coverage under the Plan.

"**Residential Treatment Center**" Is a live-in health care facility providing therapy for traumatic brain injury, stroke, other acquired brain injuries, substance abuse, mental illness, or other illnesses that differs from skilled nursing care in that patients in Residential Treatment Centers live in facilities together with other patients receiving therapy and do not need assistance with activities of daily living and do not need 24/7 skilled nursing care.

"**Routine Well Newborn Nursery Care**" Is care while the newborn is Hospital confined after birth and includes room, board, and other normal care for which a Hospital makes a charge.

"Routine Eye Examination" Is screening/preventive eye examination, prescription of lenses or monitoring of contact lenses for refractive error correction other than bandage lenses or keratoconus lens therapy. Routine eye exams produce a final diagnosis, like nearsightedness, farsightedness or astigmatism and may be performed by an optometrist or ophthalmologist.

"**Skilled Nursing Facility**" This is a facility that is licensed to provide professional nursing services on an inpatient basis to persons convalescing from illness or injury. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided. In addition, its services must be provided for compensation and under the full time supervision of a Physician, it provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse, it maintains a complete medical record on each patient, has

an effective utilization review plan, is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or Educational care, or care of Mental Disorders, and is approved and licensed by Medicare.

"**Special Enrollee**" A Covered Individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan and during a Special Enrollment Period. A Late Enrollee is not a Special Enrollee.

"**Special Enrollment Period**" Is the period of time during which a person may become a Covered Individual if they do not enroll within 30 days of eligibility.

"**Spouse**" This is an individual who is treated as the Covered Employee's spouse for federal tax purposes. A common-law spouse shall be eligible for coverage under this Plan if the foregoing requirement is met and the Covered Employee submits a written notarized statement affirming the person as his or her spouse and naming the state of marriage. An individual who is legally separated or divorced from the Covered Employee is specifically excluded from the definition of Spouse. The Plan Administrator may require documentation of an individual's status as a Spouse.

"**Substance Abuse**" Any use of alcohol, any Drug, any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug.

"**Telemedicine**" The use of interactive audio, video or other electronic media (excluding telephone or fax machines) to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

"**Temporomandibular Joint (TMJ) Syndrome**" The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

"**Urgent Care**" Urgent Medical Condition means a medical or behavioral condition other than an emergency condition, manifesting itself by acute symptoms of sufficient severity that, in the assessment of a 'prudent layperson', possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ, body part, or mental ability, or any other condition that would place the health or safety of the Enrollee or another individual in serious jeopardy in the absence of medical or behavioral treatment within twenty-four (24) hours.

"**USERRA**" The Uniformed Services Employment and Reemployment Rights Act of 1994.

"**Usual and Customary Rate**" The median of ACTIN's rates with its directly contracted hospitals (Alexian Brothers Hospital Network and Loyola University Medical

Center) and its directly contracted professional providers using the same method of payment, specifically Medicare's method of inpatient and outpatient facility payments with no outlier payments for facility services.

"**Utilization Review**" The process in which the utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment or will determine if the services meet the definition of Medically Necessary as defined by the Plan. The Utilization Review Administrator may be made available through the Claims Administrator or a separate entity with a direct contractual relationship with the Plan

"Vision Services" Vision Services involve the diagnosis and medical and surgical treatment of eye disease, disorders and injuries. Services include routine eye exams, medical eye exams, special ophthalmological services and surgeries related to the eye and ocular adnexa.

"**WHCRA**" It is The Women's Health and Cancer Rights Act of 1998.

ARTICLE II
PLAN STRUCTURE

2.1 Purpose

This Article details amounts Covered Individuals pay as Cost-Sharing Amounts, specifies the In-Network Providers, the Plan's responsibilities for Out-of-Network providers and services and Plan processes for Pre-Authorization of services.

2.2 This Plan Does Not Pay All Medical Expenses

It pays certain expenses under certain circumstances. For an expense to be covered under this Plan, a number of requirements must be met including:

- The person receiving the service must be a "**Covered Individual**".
- The "**Covered Individual**" has a Membership Identification Card.
  - Identifying the Individual Number of the "**Covered Employee**".
- The service must be a "**Covered Services**".
- The expense must meet the requirements of a "**Covered Charge**".
- The Covered Individual must pay any applicable "**Cost-Sharing Amounts**".

2.3 Cost-Sharing Amounts

Cost-Sharing Amounts are amounts that a Covered Individual is responsible for paying for a Covered Charge. Examples include Deductibles, Co-Payments and

Co-Insurance percentages. Amounts differ for in-network vs. out-of-network providers. Cost-Sharing Amounts for Covered Services provided by In-network providers apply to the individual's responsibility and continue to apply until the annual obligation is satisfied. Cost-Sharing amounts for out-of-network providers not approved by ACTIN have no maximum amounts, in that services or products delivered by unapproved out-of-network providers except in an Emergency are not Covered Services. Deductibles are not part of the current Cost-Sharing structure. The Plan reserves the right to impose deductibles in the future after giving proper notice. "**Co-Payments**" are dollar amounts, assessed per occurrence of service. "**Co-Insurance**" is expressed as a percentage of the Covered Charge and, when added to the covered percentage will equal 100% of the covered amount. An out-of-pocket annual maximum is the total dollar amount of all Cost-Sharing obligations for a Covered Individual for a given year. There is an individual and family annual maximum obligation.

2.4 Secondary Coverage

Failure to obtain secondary coverage may result in the beneficiary incurring costs which are not covered by the Plan, which would otherwise be covered by the secondary coverage, except to the extent that such costs are payable in any event by the Plan.

2.5 In-Network Providers

In-Network Providers are those with whom ACTIN has a direct contract or has a contract through a third party, First Health Group Corp. Under this Plan, Covered Individuals may receive different levels of coverage depending on where Covered Services are received. Generally, services received from an In-network provider will be covered at the highest level under the Plan. The Plan pays benefits based on Covered Charges, not billed charges. "**Covered Services**" are determined in accordance with Medical Necessity. Prices are determined by reference to the payment systems employed by The Center for Medicare and Medicaid Services (CMS). If the services are not Medically Necessary, the Plan will not pay and Covered Individuals may be responsible for such amounts. These amounts will not be counted toward the satisfaction of annual out of pocket obligations. The Plan has only one Tier of providers. All providers who are not In-Network are Out-of-Network.

Provider Directories

The updated provider directory can be found on the "Member's tab" then "Physician Lookup" Tab at www.actincare.com. First Health contracted hospitals and urgent care centers can be found on the "Member's tab" then "Emergency Hospitals" tab.

Professional Providers Directly Contracted with ACTIN

ACTIN has contracts with many facilities and physicians. Directly contracted physicians (not contracted through First Health) may be found at www.actincare.com, Members Tab, Provider look up.

Professional Providers and Facilities Contracted with ACTIN through First Health

- **First Health Providers**

  ACTIN has direct contracts with providers but also contracts with First Health for its national network of providers. All services by First Health providers that are not designated as in-network are out-of-network and not Covered Services. In-network services for First Health contracted providers are:

  - Urgent care visits at any First Health contracted facility 100 miles or more from the employer's primary work site.
  - Emergency Department visits and emergency hospitalizations at First Health contracted hospitals 100 miles or more from the employer's work site.
  - Inpatient Obstetric Services and women's sterilization and IUD insertion services at a First Health Contracted hospital subject to Pre-Authorization by ACTIN.
  - Professional services for Inpatient and Outpatient Prenatal and Postnatal care and women's sterilization and IUD insertion services by a First Health contracted provider subject to Pre-Authorization by ACTIN.
  - Professional Services for Outpatient Occupational Therapy by a First Health contracted provider subject to Pre-Authorization by ACTIN.
  - Professional Services for Outpatient Speech Therapy by a First Health contracted provider subject to Pre-Authorization by ACTIN.
  - Non-emergency and urgent care services for dependents under age 26 living more than 25 miles from the employee's residence.
  - Urgent Care at Aurora Urgent Care, Lake Geneva and Elkhorn, Wisconsin

Facilities Directly Contracted with ACTIN

- **Durable Medical Equipment**

  This includes respiratory services. Integrated Home Care Services, 5027 Harrison Ave, Rockford, IL 61108. Phone: 815-965-9454

- **Home Health Services**

  Able Home Health is ACTIN's home health provider for Winnebago and Boone Counties. Able's corporate address is 1946 Daimler Road, Rockford, IL 61112. Phone: 800-979-2253.

  Alexian Brothers Home Health, Contact Actin 779-216-5522

- **Hospice Services**

  Hospice Care of America is ACTIN's hospice and palliative care provider. Hospice Care of America is located at 3815 N. Mulford Rd., Rockford, IL 61114. Phone: 815-316-2700 or 888-206-9972.

  Alexian Brothers Hospice
  Contact ACTIN 779-216-5522

- **Hospital Inpatient and Outpatient Services**

  St. Alexius Medical Center: which includes Alexian Brothers Women and Children's Hospital at Hoffman Estates. Alexian Brothers Behavioral Health Hospital and Alexian Brothers Medical Center, which includes Alexian Rehabilitation Hospital, located at Elk Grove Village

  Loyola University Medical Center in Mayfield, Illinois: Loyola University Medical Center provides services only when Alexian Brothers Hospital Network cannot. ACTIN's medical director makes the judgment as to whether a service is available at Alexian Brothers Hospital Network or not.

- **Imaging**

  - CTs, MRIs, ultrasound studies, mammography and plain x-rays at Summit Radiology, 3849 N Perryville Rd., Rockford, IL 61107 Phone: 815-654-2486.

  - PET and MR Arthrography only-Forest City Diagnostic Imaging, 735 N Perryville Rd # 2, Rockford, IL 61107

  - CT and MRI, Center for Diagnostic Imaging, 4 Cedar Ridge Dr. Suite D Lake in the Hills, IL 60156

- All Studies, Center for Diagnostic Imaging, 1416 South Randall Road, Suite 180, Geneva, IL 60134
- Plain X-Ray, Lake Immediate Care & Clinic, 521 Kora Lane. Island Lake, IL 60042
- Ultrasound and Bone Density Studies, Healthy Habits Key to Wellness, 2971 West Algonquin Road, Suite 103 Algonquin, IL 60102
- Any imaging studies done at Alexian and Loyola are covered.
- Contracted specialists may perform plain x-rays and ultrasound
- studies in their offices during care but not MRI and CT scans.

- **Laboratory**
  - Lab Corp
  - Quest with Quest Lab Card
  - Office of Dr. Dale Gray
  - Health Labs
- **Other Diagnostic Studies**
  - Diagnostic studies done at Alexian and Loyola.
  - Contracted specialists may perform other diagnostic studies covered in your Plan in their offices in the course of your care
- **Physical Therapy**
  - Athletico Physical Therapy
  - OSTI Physical Therapy
- **Urgent Care**
  - Physicians Immediate Care—see Physicians Immediate Care Members Tab, Provider Lookup Tab at www.actincare.com for locations.
  - Urgent Care at Aurora Urgent Care, Lake Geneva and Elkhorn, Wisconsin through First Health

- Lake Immediate Care & Clinic, 521 Kora Lane. Island Lake, IL 60042
- MedExpress Urgent Care, 226 S Randall Rd, Algonquin, IL 60102

- **Skilled Nursing Facility**
  - TBD
- **Outpatient Dialysis**
  - Outpatient dialysis facility services are a Covered Service but the Plan has no in-network dialysis facility providers and no professional providers of dialysis services except Nephrology Associates of Northern Illinois who are directly contracted with ACTIN.

2.6 Out-of-Network Providers

Non-Emergency

The plan is under no obligation to pay for non-approved, non-emergency out-of-network services. Non-approved, non-emergency out-of-network services are not Covered Services.

- The Plan will approve professional services, but professional services only, for a Covered Individual's designated Primary Care Provider who is out-of-network. In this circumstance, the Plan will reimburse the Covered Individual the median of the Plan's contracted rate for physicians. The Covered Individual is responsible for any difference in what the provider charges and the amount that the plan reimburses the Covered Individual. The difference does not apply to the out of pocket maximum.

Emergency

For out-of-network ER visits and emergency Hospital Admissions to out-of-network hospitals, the Plan pays Covered Services at the median of its contracted rates with Alexian Brothers Hospital Network and Loyola University Medical Center with no outlier payments and payment by Diagnostic Related Group (DRG), Outpatient Prospective Payment System (OPPS) and by CPT code. For out-of-network ground ambulance transport the Plan pays the median of its contracted rates with ATS Medical Services. For out-of-network air transport the Plan pays the prevailing Medicare rate. Professional Services and all other emergency services

are paid at the median of ACTIN's contracted rates for physician and professional services. The Covered Individual is liable for the difference in what the Plan pays and what the providers charge for emergency services received at out-of-network hospitals.

For out-of-network ER visits and emergency Hospital Admissions, the Plan may reimburse providers up to 200% of Medicare rates for facility payments and 160% of Medicare for professional services if necessary to prevent balance billing of Members. The Plan reserves the right to allow additional reimbursement levels based on a combination of condition severity, provider availability, geographic and market conditions.

Emergency services provided at a hospital Emergency Department that are reviewed after provision of service and found not to be Medically Necessary under the Plan's definition of an Emergency, are not Covered Services. If a licensed physician, Physician's Assistant, or Nurse Practitioner refers the patient to the Emergency Department, the service is Medically Necessary and not subject to review for Medical Necessity.

NOTE: Alexian Brothers Hospital Network and Loyola University Medical Center are the only hospitals in network for emergency department visits and emergency hospitalizations within 100 miles of employer worksite. First Health hospitals are in network for emergencies outside the 100-mile radius of the employer's worksite.

Network Adequacy When a Covered Individual has made a good faith effort to utilize in network providers for a covered service and the ACTIN determines that due to insufficient numbers or types of in-network providers or an impracticable distance to see them, the Covered Individual will be provided covered service at no greater cost to the Covered Individual than if the service had been provided by an in-network provider. Whenever the ACTIN or an in-network provider finds it medically necessary to refer a beneficiary to an out-of-network provider, the Covered Individual so referred shall incur no greater out of pocket liability than had the Covered Individual received services from an in-network provider. This provision does not apply to a Covered Individual who willfully chooses to access an out-of-network provider for health care services available through the Plan's panel of participating providers.

2.7 Pre-Authorization by ACTIN.

- **Pre-authorization by ACTIN for Specialist Visits**

  Covered Individuals are required to inform ACTIN when they seek referral to a physician other than their Primary Care Provider and ACTIN then sends authorization to the Third-Party Administrator and the physician. All new referrals to a specialist (any physician other than the Covered Individual's

designated PCP) and specialist follow-up visits require authorization by the ACTIN and referrals by the Covered Individual's Primary Care Provider with three exceptions:

- Visits during the global period after a surgical procedure.
- Visits to an obstetrician/gynecologist for pre-natal and post-partum care.
- Visits to Dr. Dale Gray, Family Medicine for McHenry County, Dr. Ignacio Omengan or Dr. Aruna Shah.

- **Penalties for Covered Individuals Seeing an In-Network Specialist without Pre-authorization by ACTIN**

  - A Covered Individual who refers themselves or is referred by any PCP or specialist to an in-network specialist and receives Covered Services without authorization by ACTIN or after ACTIN's written authorization has expired is subject to $75 Penalty in addition to any co-insurance if Pre-Authorized according to the amounts listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule as applicable.
  - Services by an out-of-network physician without authorization are not Covered Services. The Plan has no obligation to pay for non-approved out-of-network services except in emergencies.
  - A Covered Individual who refers themselves or is referred by any PCP or specialist to an in-network Behavioral Health Care Provider and receives Covered Services without authorization by ACTIN or after ACTIN's written authorization has expired is subject to $75 Penalty in addition to any co-insurance if Pre-Authorized according to the amounts listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule as applicable.

- **Providers for whom no Pre-authorization by ACTIN is required (PCPs):**

  - Dr. Ignacio Omengan: *ACTIN direct contract*
  - Dr. Aruna Shah: *ACTIN direct contract*
  - Dr. Dale Gray: *ACTIN direct contract'*
  - Family Medicine for McHenry County *direct contract*

- An Obstetrician or Gynecologist providing prenatal or post-partum care
- An approved out-of-network PCP designated as the Members PCP including Obstetrician/Gynecologists providing primary care services.

2.8 Pre-Authorization by MCM

- **Pre-authorization of Hospital Admission and Organ and Tissue Transplants.**

  Preadmission, Admission and Continued Stay Review will be performed by MCM Solutions for Better Health, 200 West Monroe Street, Suite 1840, Chicago, IL. Pre-authorization can be initiated by calling MCM at 888-367-9938 or FAX 312-236-8547 or at http://www.medicalcost.com. All elective, urgent and emergency admissions and admission for organ transplantation will be reviewed. MCM bases Medical Necessity decisions upon Interqual criteria and physician review, and Plan Language. Only those days and services determined to be Medically Necessary and appropriate shall be recommended for certification. Days and services, which are not recommended for certification, shall follow non-certification and "**Appeal**" procedures. Final certification shall not be made before the entire Utilization "**Review**" process is complete. This includes the performance of any required physician advisor review.

  Hospital pre-admission and admission review include inpatient settings in which daily physician interaction takes place including acute inpatient hospital, long-term acute care hospital, inpatient rehabilitation, inpatient mental health facility, and inpatient substance abuse facilities. 23-hour observation does not require pre-authorization by MCM or by ACTIN. However, if patient converts from 23-hour observation to inpatient, this will require pre-authorization. MCM's Preadmission and Admission Review program includes a length of stay assignment. The continued Stay Review Program shall be conducted for all admissions subject to Preadmission Review.

- **Pre-authorization of Certain Inpatient and Outpatient Tests and Procedures.**

  MCM determines Medical Necessity and appropriateness for some outpatient procedures and services as follows:

Inpatient Services:

All inpatient Non-Emergency Hospital admissions including surgical, obstetric, and medical admissions, rehabilitation hospital, behavioral health hospital, and long term acute care.

Outpatient Services Requiring Pre-Authorization by MCM

- Home Health
- Partial hospitalization for chemical dependency and behavioral disorders and other conditions.
- Sleep studies
- Hospice
- MRI, CT and PET
- Occupational, Speech and Physical Therapy
- Outpatient Behavioral Health and Substance Abuse Services
- Skilled Nursing facility
- Outpatient dialysis
    - All outpatient diagnostic and therapeutic procedures that require the penetration of the body or a body orifice by a trocar, a catheter, an endoscope or a medical device with a light attached, or an incision, require Pre-Authorization, with the following exceptions when the procedure is performed in a physician's office.

      Nasal endoscopy-31231

      Laryngoscopy-31575

      Binocular Microscopy-92504

      Control Nasal Hemorrhage-30901

      Removal of impacted cerumen-69210 and 69201

      Urodynamics-51725 and 51798

      Surgery of the Integumentary System-10021-19499

      Injection of joints-20600, 20604, 20605, 20606, 20610, and 2061

Note: Nasal sinus endoscopy with dilation of maxillary, frontal and/or sphenoid sinus ostia is not a Covered Service.

- **Pre-Authorization of Durable Medical Equipment**

  The Plan requires that Durable Medical Equipment costing more than $500 have Pre-Authorization before obtaining these Covered Services. Pre-Authorization for Durable Medical Equipment and supplies for the equipment (such as for Insulin pumps and Continuous Glucose Monitors), must be received from either the Plan's case management nurse or MCM.

- **Failure to Pre-Authorize**

  Failure to obtain pre-authorization for services that require pre-authorization under this Plan will result in the Covered Individual being responsible for a $75 Penalty to the provider in addition to any other applicable co-insurance.

2.9 Designated PCP

Each Covered Individual must have a Primary Care Provider either designated by or reported to ACTIN. ACTIN keeps records of each Covered Individual's designated PCP. There are never pre-authorization requirements for Covered Individuals to see their designated PCP nor are there out-of-pocket costs for a Covered Individual's In-Network PCP. The Covered Individual's options for a PCP are:

- **Primary Care Provider (PCP) for Adults**

  Each Covered Individual must designate a Primary Care Provider and report that provider's name to ACTIN's ACTIN. Covered Individuals have 4 choices of PCPs:

  - Dr. Dale Gray
  - Family Medicine for McHenry County, 1095 Pingree Rd, Crystal Lake, IL 60014
  - An Obstetrician or Gynecologist contracted with ACTIN.
  - An approved, out-of-network PCP including Obstetrician or Gynecologist for Women's Health—the Covered Individual is responsible for payment above the Plan's median physician payment amount.
  - Members may change Primary Care Provider once during the Plan Year

  NOTE: The Covered Individual pays the provider and is reimbursed by the Plan at the Plan's median rate for ACTIN directly contracted physicians. The Covered Individual is responsible for any difference between the Plan's median payment rate for professional services and the provider's charges. Any difference in what the Covered

Individual pays and the Plan reimburses does not apply to the out-of-pocket maximum.

- **Primary Care Provider (PCP) for Children**

The parent of each Covered Individual who is less than 18 years of age must designate a PCP and report that provider's name to ACTIN. Covered Individuals who are less than 18 years have 3 choices of PCPs:

- Dr. Ignacio Omengan who is directly contracted with ACTIN.
- Dr. Aruna Shah who is directly contracted with ACTIN.
- Family Medicine for McHenry County, 1095 Pingree Rd, Crystal Lake, IL 60014
- An approved, out-of-network PCP—the Covered Individual is responsible for payment above the Plan's median payment amount.

NOTE: The Covered Individual pays the provider and is reimbursed by the Plan at the Plan's median rate for contracted physicians. The Covered Individual is responsible for any difference between the Plan's median payment rate for professional services and the provider's charges. Any difference in what the Covered Individual pays and the Plan reimburses does not apply to the out-of-pocket maximum.

- **Failure to Designate a PCP**

- If within 3 months of Annual Enrollment or Re enrollment a Member fails to designate a PCP then the individual is automatically assigned to a PCP contracted with ACTIN.
-

2.10 Medical Benefits Schedule

- *Annual Deductible*: $0
- *Out of Pocket Maximum per person* for Medical services: $500 (amounts are **not** rolled over from year to year)
- *Out of Pocket Maximum per family for Medical services*: $1000 (amounts are **not** rolled over from year to year)
- *Pre-existing Condition Limitation*: None
- *Lifetime Maximum Benefit*: None

- *$300 Emergency Department Facility Penalty per ER visit unless admitted and $1000 facility Penalty for deliveries in First Health hospitals other than Alexian Brothers Hospital Network Facilities and Loyola University Medical Center, except in an emergency, Penalties for failure to preauthorize, and charges above what the plan pays for approved out-of-network non-emergency care and for out-of-network emergency care (balance billed charges) are not included in out-of-pocket maximum.*

- **Bariatric Surgery**

  30% co-insurance - must be pre-authorized -failure to pre-authorize results in $75 Penalty for facility services in addition to co-insurance.

  -

- **Behavioral Health Care**

  Behavioral Health Care must be pre-authorized by MCM after the first visit. The first visit must be pre-authorized by ACTIN. Failure to pre-authorize the first visit results in $75 Penalty for that visit in addition to any co-insurance if Pre-Authorized according to the amounts listed in the Medical Benefits Schedule or Pharmacy Benefits Schedule as applicable. Failure to pre-authorize by MCM for subsequent visits could result in non-payment to the provider if the services are not Covered services.

  - *Office Visit*: 30% co-insurance
  - *Behavioral Disorder Intensive Outpatient Therapy*: 30% co-insurance (20 visits maximum must and must be pre-authorized)
  - *Behavioral Disorder Inpatient and Partial Hospitalization*: 30% co-insurance
  - *Chemical Dependency Office Visit*: 30% co-insurance
  - *Chemical Dependency Intensive Outpatient Therapy*: 30% co-insurance (20 visits maximum and must be pre-authorized)
    - *Chemical Dependency Inpatient Treatment and Partial Hospitalization*: 30% co-insurance

- **Durable Medical Equipment, "Prosthetics", and "Orthotics".** ***Require Pre-Authorization***—failure to Pre-Authorize results in $75 Penalty. There is no coverage if out of network Durable Medical Equipment is not preauthorized.

  - *Orthotics: 30% co-insurance-must be Pre-Authorized*

- *Hearing Aids: $500 per ear: once every 4 years (no co-insurance or copays)*
- *Durable Medical Equipment and Supplies:* 30% co-insurance must be Pre-Authorized
- The Plan makes the determination of whether equipment is rented or bought
- *Prosthetic Devices*: 30% co-insurance —must be Pre-Authorized.

- **Emergency Care**

  - *Ambulance Services*: 30% co-insurance
  - *Hospital Emergency Room (non-obstetric emergencies) anywhere, all hospitals*: $300 facility Penalty plus 30% co-insurance. Penalty is waived for hospital admission or 23 Hour Observation if Covered Individual is admitted.

    NOTE: Emergency Room visits that are not Medically Necessary (non-emergencies) are not covered.

  - *Emergency Hospital* admission anywhere, all hospitals (non-obstetric emergencies): $300 facility Penalty plus 30% co-insurance. $300 facility Penalty is waived if the patient is admitted.
  - *Physician Services during Emergency Hospitalization and Emergency Room visits*: 30% co-insurance
  - *Emergency Hospital Admissions for Obstetric emergencies*: $0
  - *Hospital Emergency Room visits for Obstetric emergencies*: $0
  - *Physician Services during Emergency Hospitalization and Emergency Room visits for obstetric emergencies*: $0
  - *23 Hour Observation*: 30% co-insurance
  - *When a Member is admitted to an out of network hospital for an emergency, the Member is transferred to an Alexian Brothers Network Hospital as soon as the admitting physician considers a transfer to be medically safe and a physician at the Alexian Brothers Hospital Network Hospital agrees to accept the transfer*.
  - *The only hospitals in network for emergencies are Alexian Brothers Network Hospitals and Loyola University Medical Center*.

- **Extended Care**

  - *Skilled Nursing Facility*: 30% co-insurance - maximum 90 days/year and must be pre-authorized – failure to pre-authorize results in $75 Penalty.

  - *Home Health Care Services*: 30% co-insurance - maximum 90 visits/year and must be pre-authorized – failure to pre-authorize results in $75 Penalty.

  - *Hospice Care Services*: 30% co-insurance - must be pre-authorized—failure to pre-authorize results in $75 Penalty.

- **Inpatient Care (All Hospital Admissions require pre-authorization** – failure to pre-authorize results in $75 Penalty.)

  - *Hospital (Semi-private room and Board)*: 30% co-insurance
  - *Surgery*: 30% co-insurance
  - *Physician*: 30% co-insurance

- **Obstetrical Care**

  - *Delivery, Inpatient facility at Alexian Brother's Hospital Network or Loyola University Medical Center*: $0
  - *Delivery, Inpatient facility at First Health Network-contracted Hospital other than Alexian Brothers Hospital Network or Loyola University Medical Center (non-emergencies)*: $1000 Penalty to facility plus 30% co-insurance for other services (maximum out-of-pocket is $1500)
  - *Maternity and Prenatal Professional Services by ACTIN-direct contracted obstetrician*: $0

- **Office Services**

Office visits to any physician other than the Covered Individual's PCP must be pre-authorized by ACTIN except obstetricians and in the global period after surgery. Failure to pre-authorize procedures that require preauthorization results in a $75 Penalty.

  - *Preventive Care*: $0

  - *Professional services and all other in-office services of Member's PCP:* $0

- *Specialist visit*: 30% co-insurance
  - Must be pre-authorized by ACTIN except obstetricians and in the global period after surgery. Failure to pre-authorize results in $75 Penalty.
- *Diagnostic lab and x-ray*: 30% co-insurance
- *Other Diagnostic Tests and Procedures*: 30% co-insurance
- Primary Care Providers may be paid by capitated rate for certain Covered Services as agreed to and contracted by ACTIN Care Groups.

- **Hospital Outpatient Surgery and Invasive Diagnostic (some procedures require pre-authorization** – failure to pre-authorize if pre-authorization is required results in $75 Penalty in addition to co-insurance).
  - Applies only to procedures performed in hospital outpatient department, not physician office.
  - Includes endoscopy, cardiac catheterization, arthroscopy, or any diagnostic or therapeutic procedure requiring insertion in an orifice or by puncture of a catheter, a trocar or a scope other than intravenous catheters inserted peripherally for intravenous infusions.
  - *Surgery, facility*: 30% co-insurance
  - *Surgery, physician*: 30% co-insurance

- **Outpatient Imaging and Electrophysiology** (failure to preauthorize procedures that require pre-authorization results in $75 Penalty.)
  - *X-ray*: 30% co-insurance
  - *MRI/CT/PET/Nuclear Medicine/ultrasound studies*: 30% co-insurance
  - EMG/EEG/Somatosensory Evoked Potentials and other electrophysiological studies not requiring insertion of a catheter, scope, or trocar other than for intravenous catheters inserted for infusions: 30% co-insurance

- **Laboratory Outpatient and Professional Services**
  - *Outpatient facility*: $0

- *Outpatient professional*: $0

- **Outpatient Dialysis**
  - *Dialysis Facility Services*: 30% co-insurance
  - *Dialysis Professional Services*: 30% co-insurance

- **Outpatient Therapy (Physical Therapy, Occupational Therapy and Speech Therapy must be pre-authorized**– failure to pre-authorize results in $75 Penalty paid for the first visit.
  - *Physical and Occupational Therapy*: 30% co-insurance - 20 visit maximum and must be pre-authorized
  - *Speech and Hearing Therapy*: 30% co-insurance - 20 visit maximum and must be pre-authorized
  - *Speech and Hearing Therapy for Pervasive Developmental Delay:* 30% co-insurance - 20 visit maximum and must be pre-authorized
  - *Respiratory Therapy*: 30% co-insurance – 20 visits maximum
  - NOTE: For expenses incurred for outpatient physical therapy, outpatient occupational therapy and only when the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time when preapproved, as shown on the Schedule of Benefits and as required by the Plan, the visit limit will not apply when pre-approval of the treatment has been obtained and is for the treatment of burns, fractures, joint replacements, immediately following surgery or immediately following a stroke.

- **Dependents Living Out-of-Area**
  - A Dependent Living Out-of-Area is defined as a Dependent living at least 6 months of the year more than 50 miles from the employee's primary residence.
    - Covered Services while the Dependent is living Out-of-Area are through First Health contracted providers during the period that the Dependent is residing more than 50 miles from the employee's primary residence: 30% co-insurance

- Dependents living out of area are not required to have a Primary Care Provider and do not require pre-authorization by ACTIN to see a specialist that is in-network.

- All co-insurance, Co-Payments, Penalties and Pre-Authorization requirements for inpatient and outpatient procedures and for emergency services apply to Dependents Living Out-of-Area.

- First Health hospitals located within 100 miles of employee's worksite are not in-network for Dependents Living Out-Of-Area as they are not in network for other Members.

- **Transportation and Ambulance Services**

  - *Medically Necessary <u>non-emergency</u> ambulance transport with in-network provider*: 30% co-insurance

  - *Medically Necessary <u>emergency</u> ambulance transport regardless if provider is in-network or out-of-network*: 30% co-insurance

- **Urgent Care 30% Co-Insurance**

  - *Physicians Immediate Care facilities*

  - *Urgent care at Alexian Hospital Network facilities*

  - Urgent Care at Aurora Urgent Care, Lake Geneva and Elkhorn, Wisconsin through First Health

  - Lake Immediate Care & Clinic, 521 Kora Lane. Island Lake, IL 60042

  - MedExpress Urgent Care, 226 S Randall Rd, Algonquin, IL 60102

- **Vision Services**

  - Routine Eye Examination: Not Covered

  - Medical Eye Examination: 30% co-insurance

  - Special Ophthalmologic Services: 30% co-insurance

- Ophthalmologic Surgery: 30% co-insurance

- Eyeglasses and Lenses: 30% co-insurance with pre-approval. One pair of eyeglasses or contact lenses are covered if the Covered Individual has a history of having had cataract surgery during the Plan year. If the eyeglasses or contact lenses were not accessed during the Plan year during which the Covered Individual had surgery, they may be accessed during the subsequent Plan year. Contact lenses are covered for a diagnosis of aphakia (absence of a lens) diagnosed during the Plan year. Coverage includes one initial lens, one replacement lens for each aphakic eye in the year in which the diagnosis was made or if not accessed in that year, in the following year. Eyeglasses and lenses are not covered except in these specific circumstances.

- **Weight Loss Programs** Weight loss programs either in groups or individually by in-network providers authorized to provide such services are covered at 30% cost sharing.

    - Weight loss programs offered by Dr. Dale Gray

    - Weight loss programs offered by Health Habits Key to Wellness

    - Weight loss programs offered by Alexian

    - Weight loss programs offered by other providers are not covered.

2.11 Pharmacy Benefits Schedule

- *Annual Deductible*: $0

- *Out of Pocket Maximum per person* for Prescription Drugs: $1000 (amounts are **not** rolled over from Calendar Year to Calendar Year.)

- *Out of Pocket Maximum per family for Prescription Drugs*: $2000 (amounts are **not** rolled over from Calendar Year to Calendar Year). All individual out of pocket amounts will satisfy the family out of pocket, but no one person will be required to pay more than $ 1000.

- The medical benefit and prescription drugs have separate out of pocket maximums.

- The difference between cost of Generic and Branded drugs for Dispensed as Written prescriptions, retail fill of specialty drugs, and cost of insulin pens, cartridges and penneedles do not apply to prescription out of pocket maximum.

2.12

Branded and Generic Drugs Purchased through ProAct Inc.

Branded and Generic Drugs Purchased through ProAct Inc.

	Generic	Brand	Non-Preferred	Day Supply
Retail	20% - Max of $10	50% - Max of $100	70% - Max of $250	1 to 30
Retail	20% - Max of $20	50% - Max of $200	70% - Max of $500	31 to 60
Retail Extended Value Network Only	20%-Max of $30	50%-Max of $300	70%-Max of $750	61-90
Mail Order	20% - Max of $50	50% - Max of $75	70% - Max of $250	1 to 30
Mail Order	20% - Max of $100	50% - Max of $150	70% - Max of $500	31 to 60
Mail Order	20% - Max of $150	50% - Max of $250	70% - Max of $750	61-90

- Any quantity of medication may be purchased by mail order or retail
  - *Mandatory Mail and Retail Generic Medication Provision*: If Substitution is not allowed by provider (DAW 1) or Substitution is allowed but patient requests the brand product (DAW 2) Member pays full cost difference between brand and generic.
  - *Generic Medications at Retail*: 20% co-insurance for 1-30-day supply to a maximum of $10.
  - *Generic Medications at Retail*: 20% co-insurance for a 31-60-day supply to a maximum of $20.
  - *Generic Medications at Retail*: 20% co-insurance for an 61-90-day supply or greater to a maximum of $30.
  - *Preferred Branded Medications at Retail*: 50% co-insurance for 1-30-day supply to a maximum of $100.
  - *Preferred Branded Medications at Retail*: 50% co-insurance for 31-60-day supply to a maximum of $200

- *Preferred Branded Medications at Retail*: 50% co-insurance for 61-90-day supply to a maximum of $300

- *Non-preferred Branded Medications at Retail and Mail*: 70% coinsurance for a 1-30-day supply to a maximum of $250.

- *Non-preferred Branded Medications at Retail and Mail*: 70% coinsurance for a 31-60-day supply to a maximum of $500.

- *Non-preferred Branded Medications at Retail and Mail*: 70% coinsurance for an 61-90-day supply to a maximum of $750.

- *Generic Medications at Mail*: 20% co-insurance for 1-30-day supply to a maximum of $50.

- *Generic Medications at Mail*: 20% co-insurance for a 31-60-day supply to a maximum of $100.

- *Generic Medications at Mail*: 20% co-insurance for a 61-90-day supply or greater to a maximum of $150.

- *Preferred Branded Medications at Mail*: 50% co-insurance for 1-30-day supply to a maximum of $75.

- *Preferred Branded Medications at Mail*: 50% co-insurance for 31-60-day supply to a maximum of $150

- *Preferred Branded Medications at Retail*: 50% co-insurance for 61-90-day supply to a maximum of $250

- *Specialty Medication*s: 20% co-insurance to a maximum of $200 per 30-day supply up to out-of-pocket pharmaceutical maximum.

- *Specialty Medications*: Co-insurance is waived if Member chooses international purchase of approved specialty drugs

- Specialty Medications: The maximum Plan spending for specialty drugs is $25,000 per Plan Year per Covered Individual.

- *Specialty Medications*: Plan will cover the cost of prescriptions filled in person, internationally for selected specialty medications prescribed by non-US physicians if pre-approved. The Plan will cover professional services and related medical costs provided by pre-approved non-US physicians attendant upon treatment of the condition for which the Member traveled. Medications prescribed by non-US physicians and professional

services provided by non-US physicians without Pre-Authorization are not covered. The supply of medications obtained by Member and brought back into the United States for personal use is limited to 90 days of medication per international trip made by the Member. More than one prescription may be filled per international trip.

The costs of travel for pre-approved days necessary to see the international physician and fill the prescription (s) are covered by the Plan. Any costs of medical care incurred on the pre-approved days of travel are covered by the Plan if those costs are related to treatment of the underlying condition for which the Member was referred or activities necessary to see the international physician and fill the prescription. Costs of treatment of medical conditions acquired on days not pre-approved for travel or not necessary to undergo the examination and fill the prescription in person or to treat the underlying condition are not covered. Co-insurance is waived for Members who elect to obtain pre-approved specialty medications from a pre-approved international physician.

Plan Sponsor will directly reimburse individual for any federal filing fees necessary to obtain a Passport and pay for any legal fees necessary for individual to obtain passport. These payments are not paid out of Plan Sponsor's claims fund.

ARTICLE III
CONTINUITY OF CARE AND TRANSITIONS OF CARE

3.1 Continuity of Care

Continuity of medical care is considered for a limited period when a physician's or professional provider's Participation Agreement is discontinued for reasons other than quality deficiencies. *ACTIN manages continuity of care*. Termination of the physician's or professional provider's Participation Agreement shall not release a physician or professional provider from the obligation to continue ongoing treatment of a Covered Individual with "special circumstances" (as defined by applicable law and regulation) or the Plan from its obligation to reimburse the physician for such services at the rate set forth in their agreement. *Special circumstances* mean a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the Covered Individual. *Special circumstances* shall be identified by the treating physician or health care provider, who must request that the Covered Individual be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the Covered

Individual of any amounts for which the Covered Individual would not be responsible if the physician or provider were still a network provider.

The physician's or professional provider's and ACTIN's obligations will continue until the earlier of the appropriate transfer of the subscriber's care to another ACTIN contracted physician or professional provider (whichever is applicable), the expiration of 90 days from the effective date of termination of the physician or professional provider, or up to nine months in the case of a Covered Individual who at the time of the termination has been diagnosed with a terminal illness. If coverage for care with an out-of-network physician or professional provider is certified due to pregnancy, it will be continued through the postpartum check-up within the first six weeks of delivery.

Continuity of care is considered when a Covered Individual has special circumstances such as:

- acute or disabling conditions
- life threatening illness
- pregnancy 3rd trimester and beyond

3.2 Transitional Benefits

If a Covered Individual or a Covered Dependent is undergoing a course of medical treatment at the time of enrolling in the Plan and the provider is **not** in network, ongoing care with the current provider may be requested for a period of time. *ACTIN manages Transitional Benefits*. Transitional care benefits may be available if being treated for any of the following conditions by a non-network provider:

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care

Transitional care benefits are subject to approval by ACTIN's ACTIN.

ARTICLE IV
COVERED CHARGES

Covered Charges are those incurred for Covered Services identified below where there use is supported by evidence based practice guidelines and Medical Necessity. These charges are subject to the benefit limits, exclusions, and other provisions of this Plan.

Acquired Brain Injury

Benefits for Medically Necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. To ensure that appropriate post-acute care treatment is provided, the Plan includes coverage for reasonable expenses related to periodic re-evaluation of the care of an individual covered who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration with services that are Medically Necessary and supported by evidence based guidelines.

NOTE: "**Day Services", "Assisted Living", and "Residential Treatment Centers"** are not Covered Services for Acquired Brain Injury or any other Illnesses under this Plan. "**Neurofeedback and Related Services**" are not Covered Services for any condition under this Plan.

Allergy Care

Coverage is provided for testing and treatment for Medically Necessary allergy care. Allergy injections are not considered immunizations for purposes of the Plan's preventive care benefit.

Ambulance Service

The Plan covers ambulance services when Medically Necessary as outlined below:

- The patient's condition must be such that any other form of transportation would be medically contraindicated.
- The patient is transported to the nearest site with the appropriate facilities for the treatment of the injury or illness involved or in the case of organ transplant, to the approved transplant facility.

Air or sea ambulance services are Medically Necessary as outlined below:

- The time needed to transport a patient by either basic or advanced life support land ambulance poses a threat to survival.
- The point of pick-up is inaccessible by land vehicle.
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities

for treatment (e.g. transport of a critically ill patient to an approved transplant facility with a waiting organ).

The following services are not Medically Necessary, as they do not require ambulance transportation:

- Ambulance services when the patient has been legally pronounced dead prior to the ambulance being summoned.
- Services provided by an ambulance crew who do not transport a patient but only render aid. Some examples are:
  - Ambulance dispatched to scene of an accident and crew rendered aid until a helicopter can be sent;
  - Ambulance dispatched and patient refuses care or transport; or
  - Ambulance dispatched and only basic first aid is rendered.

Non-emergency transports between medical facilities may be considered Medically Necessary for a patient who has a medical problem requiring treatment in another location and is so disabled that the use of an ambulance is the only appropriate means of transfer. Disabled means the patient's physical condition limits his mobility and is unable to stand and sit unassisted or requires continuous life support systems. Non-emergency transport from a patient's home is not a Covered Service.

Transfers in medical vans or commercial transportation (such as public transportation, taxi or commercial vehicle) are not reimbursable or covered except when preapproved for Covered Individuals who cannot reasonably be expected to drive under three specific circumstances:

- From Covered Individual's residence to a specialty visit at least 50 miles away.
- From Covered Individual's residence to a "**Hospital Admission**" or a "**Hospital Discharge**" at least 50 miles away.
- From Covered Individual's residence to outpatient services at least 50 miles away.

The criteria used in approving such transportation are:

- The Covered Individual's family income.
- The Covered Individual's mode of transportation to employment.
- The age, number and condition of the Covered Individual's vehicles.
- The Covered Individual's ability to drive.

- Any extenuating circumstances that support the Covered Individual's inability to transport him/herself.

ACTIN is responsible for determining transportation coverage and informing the Third Party Administrator of the approval and the amount.

Anesthetic

Are oxygen, blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

Autism

The Plan covers children and adults under the age of 21 for the diagnosis and treatment of autism spectrum disorder up to an annual dollar limit of $10,000. The following services are covered:

- Psychiatric care provided by a licensed psychiatrist;
- Psychological care provided by a licensed psychologist or licensed clinical social worker;
- Habilitative and rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
  - Self-care and feeding
  - Pragmatic, receptive, and expressive language
  - Cognitive functioning
  - Motor planning
  - Sensory processing

NOTE: "**Applied Behavioral Analysis**": and modification are not Covered Services, as defined in the "*Excluded Services*" section.

Behavioral Health Care P*re-Authorization required for all inpatient care, partial hospitalization and outpatient care.* The Plan covers charges for inpatient and outpatient Behavioral Health Care for:

- Diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin.

- Diagnosis or treatment of any symptom, condition, disease or disorder by a provider, or any person working under the direction or supervision of a provider, when the eligible expense is:
  - Individual, group, family or conjoint psychotherapy
  - Counseling
  - Psychoanalysis
  - Psychological testing and assessment
  - Hospital visits or consultations in a facility providing such care
  - Electroconvulsive treatment

NOTE: Office visits for marital or couples counseling are not covered. Treatment in a Residential Treatment Facility is not a Covered Service.

Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services by a provider, during pregnancy and/or in the post-partum period. Benefits include the purchase or rental of manual breast pumps, accessories and supplies when purchased from an in-network provider.

Note: Electric Breast pumps are not covered.

Cardiac Rehabilitation

Cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

- Under the supervision of a Physician;
- In connection with a myocardial infarction, coronary occlusion or bypass surgery;
- Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
- In a "**Medical Care Facility**" as defined by this Plan.

Cervical, Thoracic or Lumbar Facet Neurotomy and Diagnostic Blocks **Must be pre-authorized*

The Plan will pay for **only one** facet neurotomy per level per side on cervical, thoracic or lumbar vertebrae per Year. Payment for cervical or lumbar diagnostic medial nerve branch blocks is limited to no more than 2 joint levels bilaterally or 3 joint levels unilaterally on the same day.

NOTE: The following procedures are not Covered Services:

- Dorsal rhizotomy
- Dorsal root ganglionectomy
- SI joint neurotomy
- Thoracic neurotomy
- Transection or avulsion of other extradural spinal nerves

Chemical Dependency Treatment

Chemical dependency is the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance. All inpatient and outpatient treatment for chemical dependency should be preauthorized by MCM, www.medicalcost.com, 888-367-9938.

A program may include different facilities or modalities, such as inpatient detoxification, inpatient rehabilitation/ treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment.

Inpatient treatment of chemical dependency must be provided in a chemical dependency treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a hospital will be available on the same basis as any other illness.

Treatment must be reasonably expected to improve the individual's condition or prevent further regression or relapse. Treatment that does not meet this standard is not Medically Necessary.

Clinical Trials

Benefits are available for services provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- National Institutes of Health;
- United States Food and Drug Administration;
- United States Department of Defense;
- United States Department of Veterans Affairs; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

NOTE: Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial. Medical services rendered in the ordinary course of care and not specific to the clinical research are the only covered services.

Complications of Pregnancy

Treatments for the complications of pregnancy are Covered Services.

Cosmetic, Reconstructive, or Plastic Surgery

Cosmetic, reconstructive and/or plastic surgery is surgery which can be expected or is intended to improve the physical appearance of a Covered Individual; or is performed for psychological purposes; or restores form but does not correct or materially restore a bodily function. For cosmetic, reconstructive or plastic surgery, the Plan covers only the following services if Medically Necessary:

- Treatment for correction of defects due to accidental injury while covered under the Plan.
- Reconstructive surgery following cancer surgery.
- Surgery performed on a newborn child for the treatment or correction of a congenital defect.
- Surgery to correct a congenital defect in a dependent child (other than a newborn child) under age 26 for the treatment or correction of a congenital defect. This does not include breast surgery.
- Reconstruction of the breast on which a mastectomy has been performed while covered under the Plan.
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses (two per plan year) and treatment of physical complications, including lymphedema, at all stages of the mastectomy if the mastectomy has been performed while covered under the Plan.

Benefits for eligible expenses will be the same as for the treatment of any other sickness as shown on the Benefits Summary. No other cosmetic, reconstructive or plastic surgery is covered unless particularly specified.

NOTE: Abdominoplasty is not a Covered Service

Diabetic Management Services

The Plan covers expenses associated with the treatment of diabetes for individuals diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Covered items include:

- **Diabetic Equipment**

  - Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);

  - Insulin pumps, continuous glucose monitors, and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies. All must be preauthorized.

- **Diabetic Supplies**

  - Test strips for blood glucose monitors
  - Lancets and lancet devices
  - Visual reading and urine test strips and tablets which test for glucose, ketones and protein
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Insulin syringes
  - Biohazard disposable containers
  - Mobile glucose monitoring systems

- **Diabetes Self-Management Training Programs**

  Includes initial and follow-up instruction concerning:

  - The physical cause and process of diabetes;

  - Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self- management of diabetes;

  - Prevention and treatment of special health problems for the diabetic patient;

  - Adjustment or lifestyle modifications; and

  - Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Training will include the development of an individualized management plan that is created for and in collaboration with the patient (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

Dietary and Medication Adherence Services

Outpatient counseling for nutrition and medication adherence is a covered service for in-network providers authorized to provide such services.

Inpatient nutritional assessment program provided in and by a network hospital is a Covered Service.

Durable Medical Equipment

Durable Medical Equipment are items which can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury or disease; and are appropriate for use in the patient's home. All requirement of the description must be satisfied before an item can be considered to be Durable Medical Equipment. Equipment to alleviate pain or provide patient comfort (for example, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene protection and home air fluidized beds) is not covered, even if prescribed by a doctor.

Benefits are provided for the following:

- Durable medical equipment, supplies and equipment covered by Medicare only.
- Two pairs of support hose per year for Members who have undergone vein surgery or procedures of lower extremities.
- Rental charge but not to exceed the total cost of the purchase of Durable Medical Equipment. Rental period may not exceed 13 months.
- Plan Sponsor makes the rent versus buy decision.
- Repair, adjustment or replacement of components and accessories necessary for effective functioning of covered equipment.
- Supplies and accessories necessary for the effective function of covered Durable Medical Equipment.

Customization:

When billing for customized DME or Prosthetic/Orthotic devices, an item must be specially constructed to meet a patient's specific need. The following items do not meet these requirements:

- An adjustable brace with Velcro closures
- A pull-on elastic brace
- A lightweight high-strength wheelchair with padding added

Repair of DME:

- Repairs of DME equipment are covered if:
  - Equipment is being purchased or already owned by the patient;
  - Is Medically Necessary; and
  - The repair is necessary to make the equipment serviceable.

Replacement Parts:

- Replacement parts such as hoses, tubing, batteries, etc are covered when necessary for effective operation of a purchased item.

DME Rental or Purchase:

- The rental versus purchase decision is made by the Plan. However, the rental of any equipment should not extend more than 13 months' duration. If the prescription indicates "lifetime" need, the supplier should sell the equipment rather than rent it. All DME in which rental or purchase are options require Pre-Authorization.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Emergency Care and Treatment of Accidental Injury

The Plan covers medical emergencies wherever they occur. For hospitals not contracted directly through ACTIN and which are thus, out of network, the Plan pays the median of its contracted rates with Alexian Brothers Hospital Network and Loyola University Medical Center with no outlier payments using Medicare's DRG when a Covered Individual is hospitalized or Medicare's APC groupers when admitted to an Emergency Room. The Plan pays out-of-network physicians and professional providers that provide services in an emergency at the median of its contracted rates for directly contracted physicians and professional providers. The Plan will negotiate rates above the median of its contracted rates with out of network hospitals and physicians as needed to prevent balance billing of Members, but Members are still liable for balance billing for emergency care at out-of-network hospitals and by out-of-network physicians.

Eyeglasses or Lenses

Eyeglasses and Lenses: One pair of eyeglasses or contact lenses is covered if the Covered Individual has a history of having had cataract surgery during the Plan year. If the eyeglasses or contact lenses were not accessed during the Plan year during which the Covered Individual had surgery, they may be accessed during the subsequent Plan year. Contact lenses are covered for a diagnosis of aphakia (absence of a lens) diagnosed during the Plan year. Coverage includes one initial lens, one replacement lens for each aphakic eye in the year in which the diagnosis was made or if not accessed in that year, in the following year. Eyeglasses and lenses are not covered except in these specific circumstances.

Hearing Aids

The Plan allows a $500 maximum benefit per ear every four years for non-disposable hearing aids. The Covered Individual may purchase the hearing aids from any provider and will be reimbursed up to $500 per ear for the cost of the hearing aid. The Covered Individual will be responsible for the difference between the benefit and the Plan's Allowable Amount. Hearing aid repair and batteries are not covered.

Home Health Care Services

The Plan covers Medically Necessary services and supplies provided in the patient's home during a visit from a home health agency as part of a physician's written home health care plan. Coverage includes:

- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational, speech, and respiratory therapy services provided by licensed therapists; and
- Supplies and equipment routinely provided by the home health agency.

Home health care benefits are subject to the following restrictions:

- Food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for custodial care are not covered.
- Charges for home health care services and supplies are covered only for care and treatment of an illness or injury when Hospital or Skilled Nursing Facility confinement would otherwise be required.
- Benefit payment home health and therapy services is subject to the Home Health Care limit shown in the Medical Benefits Schedule.

- The diagnosis, care, and treatment must be certified by the treating Physician and be contained in a Home Health Care Plan.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Hospice Care Services and Supplies

The Plan covers services provided by a hospice to patients confined at home or in a hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

The following services are covered for home hospice care:

- Part-time or intermittent nursing care by a registered nurse (RN), advanced practice nurse (APN), or licensed vocational nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Physical, respiratory, and speech therapy by licensed therapists; and
- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling.

Covered facility hospice care includes:

- All usual nursing care by a registered nurse (RN), advance practice nurse (APN), or licensed vocational nurse (LVN);
- Room and board and all routine services, supplies and equipment provided by the hospice facility;
- Physical, speech and respiratory therapy services by licensed therapists; and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

Hospice services are subject to the following restrictions:

- Charges for hospice care services and supplies are covered only when the treating Physician has diagnosed the Covered Individual's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.
- Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or Covered Dependent Children) must be furnished within six months after the patient's death.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Hospitalization

The Plan has made contractual arrangements with certain hospitals. Covered Charges for services, supplies, room and board will be payable in accordance with the Medical Benefits Schedule. Types of hospitalization included in the plan are:

- Medical/Surgical Inpatient Services
- Mental/Behavioral Health Inpatient Services-Mental health and substance abuse services
- Substance Abuse Disorder Inpatient Services
- Delivery and All Inpatient Services for Maternity Care
- Inpatient Rehabilitation Services

The Plan covers room and board (up to the hospital's semiprivate room rate; a private-room rate is allowed only when Medically Necessary), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rental.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Infertility Services

This refers to the care, supplies and services for the diagnosis and surgical correction of infertility. Testing for problems of infertility is covered. Medications for ovulation induction to reverse anovulation or oligo ovulation are covered.

NOTE: Services or supplies, including testing such as Hysterosalpingogram, provided for, in preparation for, or in conjunction with in vitro fertilization and artificial insemination are not covered. In vitro fertilization services are **not** covered.

Imaging Services

Medically Necessary radiographic procedures, services and materials, including diagnostic X-rays, fluoroscopy, and therapeutic radiology services are covered when ordered by a provider.

Laboratory Studies

Charges for diagnostic and preventive care lab testing and services are covered.

Male Sexual Dysfunction

Coverage for male sexual dysfunction may be allowed if the patient has a documented disease resulting in impotence. The surgical procedures, supplies, or medications used for treatment of male sexual or erectile dysfunction include, but are not limited to, the following:

- Inflatable or non-inflatable penile implants (prostheses)
- Vacuum erection devices
- Intracavernosal injection therapy
- (Trans)urethral suppository method

NOTE: The use of the procedures, supplies, or medications for treatment of psychologic/psychogenic male sexual or erectile dysfunction/impotence is not eligible for coverage.

Maternity Care

The Plan covers maternity-related expenses for "Covered Employees" and "Covered Dependents". Maternity care includes diagnosis of pregnancy, pre- and post-natal care and delivery (including delivery by Caesarean section). The Plan covers inpatient care for the mother and newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery and for a minimum of 96 hours following an uncomplicated delivery by Caesarean section. "Uncomplicated" means a delivery without complications of pregnancy.

When delivering at Swedish American Hospital, Rockford Memorial Hospital or a hospital contracted with First Health and with physicians contracted with First Health:

- If the mother is a Covered Individual, she will be responsible for 30% co-insurance payments for facility and professional services (except emergency obstetric admissions).
- If the mother is a Covered Individual, she will be responsible for the first $1000 of facility payments in addition to 30% co-insurance up to the out of pocket maximum. The $1000 Penalty for facility services does not apply to the out of pocket maximum.
- A separate inpatient co-insurance amount will not be charged for the newborn.
- Care of the newborn will be covered independent of the mother's care starting the day after delivery.
- Routine Well Newborn Nursery Care is covered.

- **Neonatal Intensive-Care** is not covered except at Alexian Hospital Network and Loyola University Medical Center except in the period when transport from the delivery hospital to one of these hospitals is judged by the Covered Individual's attending physician not to be medically safe. In this circumstance, the Plan pays the hospital in which the child was delivered the median of its contracted rates and the Member is responsible for any difference in what the plan pays and the hospital charges. Neonates requiring Neonatal Intensive Care are transferred from the delivery hospital to Alexian Hospital Network or Loyola University Medical Center as soon as such transport is judged by the Covered Individual's attending physician to be medically safe.
- Co-insurance and Penalties for emergency hospital admissions for Obstetric emergencies are waived.

When delivering at Alexian Brothers Hospital Network or Loyola University Medical Center with physicians directly contracted with ACTIN:

- If the mother is a Covered Individual, there are no Co-Insurance nor Penalty amounts for professional or facility services for either the mother or the newborn.
- Care of the newborn will be covered, independent of the mother's care, starting the day after delivery.
- Routine Well Newborn Nursery Care is covered.
- Neonatal Intensive Care is covered.

Midwives

The Plan will only allow benefits for midwife services provided by an advanced practice nurse (APN).

Newborn Coverage

- This coverage is only provided if:
  - The newborn child is an eligible Dependent

AND a parent:

- Is a Covered Individual who was covered under the Plan at the time of the birth; OR
- Enrolls in accordance with the Plan's Special Enrollment Rights with coverage effective as of the date of birth.

- Routine well newborn nursery care is covered at all hospitals that are in network for obstetric care.
- Neonatal ICU care is only covered at Alexian Brothers Hospital Network and Loyola University Medical Center.

Medical Surgical Expenses *(all inpatient and some outpatient medical surgical expenses require Pre-Authorization).*

The Plan provides coverage for medical-surgical expenses for Covered Individuals and Covered Dependents. These include:

- Services of physicians and other professional providers.
- Services of a certified registered nurse-anesthetist (CRNA).
- Diagnostic X-ray and laboratory procedures.
- Radiation therapy.
- Anesthetics and its administration, when performed by someone other than the operating physician or other professional provider.
- Oxygen and its administration provided the oxygen is actually used.
- Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Covered Individual.
- Prosthetic appliances, required for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the Covered Individual's effective date of coverage under the Plan, excluding all replacements of such devices other than those necessitated by growth to maturity of the Covered Individual.
- Services or supplies used by the Covered Individual during an outpatient visit to a hospital a therapeutic center, or a chemical dependency treatment center, or scheduled services in the outpatient treatment room of a hospital.
- Certain diagnostic procedures including, but not limited to, bone scan, cardiac stress test, CT scan, MRI, myelogram, PET Scan.
- Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
- Injectable drugs, administered by or under the direction or supervision of a physician or other professional provider.

Services and supplies for medical-surgical expense must be furnished by or at the direction or prescription of a physician or other professional provider. A service or supply

is furnished at the direction of a physician or other professional provider if the listed service or supply is:

- Provided by a person employed by the directing physician or other professional provider.
- Provided at the usual place of business of the directing physician or other professional provider.
- Billed to the patient by the directing physician or other professional provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Obesity

Surgical treatment of morbid obesity may be a Covered Service when:

- It is determined to be Medically Necessary; and
- It satisfies the following criteria:
  - Age >18
  - Primary bariatric surgery, not revisions
  - BMI>40 kg/m2
  - Documented history of weight management attempts
  - Unable to maintain sustained weight loss
  - No active peptic ulcer disease or gastritis or peptic ulcer disease or gastritis evaluated and treated
  - Endocrine causes of obesity excluded
  - Dietary consultation
  - No smoking by history or smoke free for at least 6 weeks.
  - No drug or alcohol misuse by history or drug and alcohol free for at least 1 year
  - No behavioral health disorder by history
  - The procedure is performed in a specialized center

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Occupational Therapy by a Licensed Therapist

Therapy must be ordered by a Physician (MD or DO) to restore fine motor skills of the upper extremities after an injury, sickness, or surgery. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Charges for occupational therapy are subject to the limits as described in the Medical Benefits Schedule.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Oral Surgery

Pre-Authorization is required. When Medically Necessary, covered oral surgery is limited to:

- Services provided to a newborn for treatment or correction of a congenital defect.
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the Covered Individual is covered by the Plan. Services must be received within 24 months of the date of the accident. (An injury sustained from biting or chewing is not considered to be an accidental injury).
- Orthognathic surgery for the treatment for obstructive sleep apnea (OSA)
- Pre- and/or post-orthognathic surgery associated orthodontia (i.e., non-cosmetic orthodontic braces)**.**
- Orthognatic surgery for the management of refractory temporomandibular joint disease in patients with persistent pain or functional limitations (jaw locking severe enough to interfere with activities of daily living), who have structural anatomic pathology (eg, internal derangement of the temperomandibular/articular disc complex) causing symptoms that do not respond to more than three to six months of initial management.
- Excision of non-dental related neoplasms, including benign tumors and cysts, and all malignant and premalignant lesions and growths.
- Incision and drainage of facial abscess.
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular

joint) due to accident, trauma, congenital defects and developmental defects or pathology.

NOTE: Dental and oral surgical procedures involving orthodontic care of the teeth are not Covered Services. Dental services except as described above are not Covered Services including partial or whole mouth extraction.

Orthognathic surgery for the improvement of an individual's facial structure in the absence of significant malocclusion is considered cosmetic and is not a covered service.

Organ and Tissue Transplants *(Pre-Authorization required)*

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver and lung) and related services and supplies are covered if the:

- Transplant is not experimental/investigational in nature.
- Donated human organs or tissue or an FDA-approved artificial device are used.
- Recipient or donor is a Covered Individual (Benefits are also available to the donor who is not Covered Individual).
- Transplant procedure is preauthorized.
- Recipient meets all of the protocols established by the hospital in which the transplant is performed.

Covered Services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches.
- Donor search and acceptability testing of potential live donors.
- Removal of organs or tissues from deceased donors.
- Transportation and storage of donated organs and tissues.
- Include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

NOTE: Services and supplies **not** covered by Plan include:

- Living and/or travel expenses of the recipient or live donor.
- Expenses related to maintenance of life for purposes of organ or tissue donation.

- Purchase of the organ or tissue.
- Organs or tissue (xenograft) obtained from another species.

Orthotics

The Plan covers orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom-designed for the purpose of assisting the function of a joint. Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the Covered Individual's responsibility.

NOTE: Non-covered items include, but are not limited to orthodontic or other dental appliances (except as allowed for accidental injury under covered oral surgery); splints or bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports and garter belts. Three pairs of elastic stockings per year are covered only for Members who have had prior vein stripping surgery performed for medical necessity, not for cosmetic purposes.

Outpatient Facility Services

The Plan covers the following services provided through a hospital outpatient department or a free-standing facility when Medically Necessary:

- Radiation therapy
- Chemotherapy
- Dialysis
- Rehabilitation services
- Outpatient surgery

Outpatient Renal Dialysis

The Plan will reimburse treatment for, or in connection with, End Stage Renal Disease (ESRD), chronic kidney disease, or other conditions requiring dialysis services subject to the following provisions:

- Outpatient Renal Dialysis facility charges are covered as out-of-network charges. the Plan has no in-network dialysis facility providers.

- All Outpatient Renal Dialysis professional providers are out-of-network, except for Nephrology Associates of Northern Illinois, which has a contract with ACTIN to provide in-network services.

The Plan provides for reimbursement of Outpatient Renal Dialysis:

- At the lesser of the provider's charges or 125% of the Medicare allowable rate for covered services, equipment, prescription drugs and supplies for the first three (3) months of Outpatient Renal Dialysis, after deduction of all amounts payable by Coinsurance and Deductibles.

- After the first three (3) months of Outpatient Renal Dialysis, at the lesser of the provider's charges or 100% of the Medicare allowable rate for covered services, equipment, prescription drugs and supplies for the next thirty (30) months of Outpatient Renal Dialysis, after deduction of all amounts payable by Coinsurance and Deductibles.

- After thirty-three months of Outpatient Renal Dialysis, at the lesser of the Provider's charges or 80% of the Medicare allowable rate for covered services, equipment, prescription drugs and supplies, after deduction of all amounts payable by coinsurance and Deductibles.

- Payment for certain prescription drugs is based on the ASP Pricing File.

- All services are subject to member cost-sharing for out-of-network costs, copayments, coinsurance and deductible.

- If the Plan payment is less than the provider's billed charges, you may be billed for the difference between billed charges and the Plan payment, if the provider is out-of-network and you do not have secondary health insurance. For maximum health insurance coverage, enrollment in Medicare upon diagnosis of ESRD is recommended to avoid, to the extent possible, uncovered charges. Medicare benefits usually start on the first day of the fourth month of dialysis treatment.

The Plan requires patients receiving ESRD-related dialysis and transplant services to ensure a CMS form 2728 is on file with the Plan no later than forty-five (45) days after a dialysis or transplant claim is submitted for reimbursement for that specific claim to be reimbursable. This document

is completed and signed at the treating facility when a patient is diagnosed with ESRD and has begun a regular course of dialysis or received a kidney transplant. The CMS 2728 form may be submitted by facsimile to the following number: 779-216-5522.

All Covered Services are subject to cost containment review, negotiation of a single patient rate agreement, and/or other related administrative services as determined at the discretion of the Plan Administrator. The Plan reserves the right to allow additional reimbursement levels based on a combination of condition severity, provider availability, geographic and market conditions.

Charges must be billed in accordance with generally accepted industry standards and with all documentation required to support billing accuracy and medical justification.

Pain Management

The focus of pain management for conditions that are not terminal in this Plan is on physical conditioning, psychological support, and non-opioid drug therapy rather than long-term opioid use. Pain management is provided by selected Primary Care Physicians, by Psychiatrists, Physical Medicine and Rehabilitation specialists and by Anesthesiologists specializing in pain management.

Podiatry

Treatment of conditions of the foot by Podiatrists is a Covered Service.

Physical Therapy by a licensed physical therapist

The therapy must be in accord with a Physician's (MD or DO) exact orders as to type, frequency, and duration, and for conditions which are subject to significant improvement through short-term therapy. Charges for physical therapy are subject to the limits as described in the Medical Benefits Schedule.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Prenatal Genetic and Chromosomal Metabolic Testing

Benefits for eligible expenses incurred for prenatal genetic and chromosomal metabolic testing include amniocentesis and chronic villus sampling (CVS). These tests are eligible only for coverage for the specific conditions listed:

- In pregnancies where the woman will be 35 years of age or over at the expected time of delivery.

- When a previous pregnancy has resulted in the birth of a child with a chromosomal (e.g. Down's Syndrome) or genetic abnormality or major malformations.
- When a chromosomal or genetic abnormality is present in a parent or there is a history of genetic abnormality in a blood relative.
- Where there is a history of multiple (three or more) miscarriages in this union or in a prior relationship of either parent.
- When the fetus is at an increased risk for hereditary error of metabolism detectable in vitro.

Preventive Services

The Plan adheres to PHS Act section 2713 and the interim final regulations relating to coverage of preventive services which require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved which are considered current;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in recommendations of the USPSTF.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques to determine any such coverage limitations.

The following Preventive Services are provided with no Cost Sharing:

- Abdominal aortic aneurysm screening for men 65-75 who have ever smoked
- Alcohol misuse counseling

- Anemia screening: pregnant women
- Aspirin to prevent cardiovascular disease in men and women
- Bacteriuria screening: pregnant women
- Blood pressure screening
- BRCA screening (includes genetic testing and genetic counseling)
- Breast cancer preventive medication (includes raloxifene and tamoxifen)
- Breast cancer screening (mammography every 2 years)
- Breast feeding counseling (includes counseling, support and equipment, *See* "*Breastfeeding Support, Services and Supplies*" for specifics of equipment)
- Cervical Cancer screening
- Chlamydial infection screening: non-pregnant women
- Chlamydial infection screening: pregnant women
- Cholesterol abnormalities screening: men 35 and older
- Cholesterol abnormalities screening: men younger than 35
- Cholesterol abnormalities screening: women 45 and older
- Cholesterol abnormalities screening: women younger than 45
- Colorectal cancer screening (includes sigmoidoscopy and colonoscopy)
- Dental caries chemoprevention: preschool children (fluoride supplementation)
- Depression screening: adolescents
- Depression screening: adults
- Diabetes Screening
- Folic acid supplementation for women capable of becoming pregnant
- Gonorrhea prophylactic medication: newborns
- Gonorrhea screening: women
- Healthy diet counseling
- Hearing loss screening: newborns
- Hemoglobinopathies screening: newborns
- Hepatitis B screening: pregnant women
- HIV screening

- Hypothyroid screening: newborns
- Iron supplementation in children
- Obesity screening and counseling: adults (includes intensive counseling and behavioral interventions)
- Obesity screening and counseling: children (includes intensive counseling and behavioral interventions)
- Osteoporosis screening: women (includes DEXA scan)
- PKU screening: newborn
- Rh incompatibility screening: 24-28 weeks gestation
- STI counseling
- Tobacco use counseling: non-pregnant adults

Includes:

  - Individual, group and phone counseling (at least 10 minutes per session
  - All FDA-approved tobacco cessation medications (prescription and over-the-counter)
  - At least two quit attempts per year
  - 4 sessions of counseling and 90 days of medication per quit attempt

- Tobacco use counseling: pregnant women (same services as non-pregnant adults)
- Syphilis screening: non-pregnant persons
- Syphilis screening: pregnant women
- Visual acuity screening in children
- Birth control services for women include all FDA-approved contraceptive methods in the following categories:
  - Surgical sterilization
  - Surgical sterilization implant
  - Implantable rod
  - Copper intrauterine device (IUD)
  - IUDs with progestin
  - Injection
  - Oral contraceptives with estrogen and progestin

- Oral contraceptive with progestin only
- Oral contraceptives—extended or continuous use
- Patch
- Vaginal contraceptive ring
- Diaphragm with spermicide
- Sponge with spermicide
- Cervical cap with spermicide
- Female condom
- Spermicide alone
- Emergency contraception-Progestin
- Emergency contraception-Ulipristal Acetate

- Childhood Immunizations

Professional Services

Covered Services must be Medically Necessary and provided by a licensed doctor or by other covered health providers as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a provider's office.

Covered Providers:

- Advanced Practice Nurse
- Certified Surgical First Assistant
- Doctor of Dentistry
- Doctor of Medicine
- Doctor of Optometry
- Doctor of Osteopathy
- Doctor in Psychology
- Licensed Audiologist
- Licensed Chemical Dependency Counselor
- Licensed Dietician
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Occupational Therapist
- Licensed Occupational Therapy Assistant

- Licensed Podiatrist
- Licensed Practical Nurse
- Licensed Physical Therapist
- Licensed Physical Therapy Assistant
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Physician Assistant
- Registered Nurse

Prosthetic Devices

The Plan provides coverage for prosthetic appliances, including replacements necessitated by growth to maturity of the Covered Individual. Coverage is provided for Medically Necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of:

- An absent body organ (including contiguous tissue), or
- The function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses)

NOTE: For purposes of this definition, a wig or hairpiece is not considered a prosthetic appliance. Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the Covered Individual's responsibility.

Radiation or Chemotherapy and Treatment with Radioactive Substances

Radiation therapy and chemotherapy are covered. The materials and services of the technician are included.

Rehabilitation Services**:** *Physical, Speech and Occupational Therapies*

The Plan covers inpatient and outpatient rehabilitation services including physical, speech and occupational therapies that are Medically Necessary, meet or exceed treatment goals for a Covered Individual, and are provided on an inpatient or outpatient basis. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Skilled Nursing Facility Care

The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- The patient is confined as a bed patient in the facility; AND
- The treating Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; AND
- The treating Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Individual's care in these facilities are payable as described in the Medical Benefits Schedule. The Plan covers care in a skilled nursing facility and pays benefits for:

- Room and board.
- Routine medical services, supplies, and equipment provided by the skilled nursing facility.
- General nursing care by a registered nurse (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN).
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Speech therapy by a licensed speech therapist

Therapy must be ordered by a Physician (MD or DO) and follow either surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person; or care that is other than a learning or related to a Mental Illness.

For further requirements for coverage, see the section of this Schedule labeled "Pre-Authorization Requirements."

Telemedicine

Telemedicine visits are paid at the rate of the Evaluation and Management code that most closely corresponds to the time and complexity of the visit or consultation.

Urgent Care

Physician's Immediate Care clinics are the only in–network urgent care centers in counties where Physicians Immediate Care has urgent care center. For urgent care in all other counties in the US, First Health contracted urgent care facilities are the only urgent care facilities covered by the Plan. Alexian Hospital Network urgent care facilities are always in-network.

Vasectomy

Vasectomy is a Covered Service.

Vision Services

The following Vision Services are Covered Services

Medical Eye Examination

Special Ophthalmologic Services

- As defined by CPT codes covered by Medicare
- Retisert (fluocinolone acetonide) intravitreal implant for the treatment of chronic non-infectious posterior segment uveitis greater than one year in duration, and in situation where there is documentation of member intolerance, or lack of significant response to conventional treatment including peri-ocular injection, and/or short course (less than 3 months) of systemic corticosteroid therapy.

Ophthalmologic Surgery

- As defined by CPT codes covered by Medicare

Eyeglasses and Lenses

- Eyeglasses and Lenses: One pair of eyeglasses or contact lenses are covered if the Covered Individual has a history of having had cataract surgery during the Plan year. If the eyeglasses or contact lenses were not accessed during the Plan year during which the Covered Individual had surgery, they may be accessed during the subsequent Plan year. Contact lenses are covered for a diagnosis of aphakia (absence of a lens) diagnosed during the Plan year. Coverage includes one initial lens, one replacement lens for each aphakic eye in the year in which the diagnosis was made or if not accessed in that year, in the following year. Eyeglasses and lenses are not covered except in these specific circumstances

NOTE: The following services are not covered: Routine Eye Examination, Crystalens implant, including as a replacement lens for post-cataract surgery; Destruction of localized lesion of choroid, transpupillary thermotherapy; destruction of macular drusen; experimental use of botulinum toxins type A and botulinum toxin type B; Lasik surgery; punctum plugs separately; radial keratotomy; refractive surgery including excimer laser and orthokeratology for correction of myopia, hyperopia, and astigmatism; Retisert for conditions other than those specified.

ARTICLE V
MEDICAL PLAN EXCLUSIONS

Excluded Charges are those services and supplies which are specifically not covered under the Plan. Any service not specifically listed as a Covered Service is excluded.

Acupuncture and Related Modalities

Any services or supplies provided for the following treatment modalities:

- Acupuncture
- Intersegmental traction
- Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Spinal manipulation under anesthesia
- Surface EMGs

Alcohol/Illegal drugs

Services, supplies, care, or treatment to a Covered Individual, arising from taking part in any activity made illegal due to the use of alcohol or illegal drugs.

Allowable Amount

It is any portion of a charge for a service or supply that is in excess of the Plan's Allowable Amount.

Any with No Legal Obligation to Pay

Any services or supplies for which a participant is not required to make payment or for which a participant would have no legal obligation to pay in the absence of this or any similar coverage, except service.

Applied Behavior Analysis

Assisted Living

Behavioral Health Services

Behavioral Health Services provided by a marriage counselor or naturopath.

Certain Vision Services

The following services are not covered: Crystalens implant, including as a replacement lens for post-cataract surgery; Destruction of localized lesion of choroid, transpupillary thermotherapy; destruction of macular drusen; experimental use of botulinum toxins type A and botulinum toxin type B; Lasik surgery; punctum plugs separately; radial keratotomy; refractive surgery including excimer laser and orthokeratology for correction of myopia, hyperopia, and astigmatism; Retisert for conditions other than those specified.

Chelation Therapy

Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

Chiropractic Care

Chiropractic care is not a Covered Service.

Clinical Ecology and Environmental Sensitivity

The inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

The Plan does not provide coverage for clinical ecology; the definition is included for clarification purposes only.

Complications of Non-Covered Treatments

Care, services, or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

Cosmetic Surgery

Expenses Incurred in connection with the care or treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent such are needed to surgically correct a body part malformed as a result of a severe birth defect, such as cleft lip or palate or webbed fingers or toes, surgically correct a body part malformed as the result of a disease or to treat disease or injury, perform reconstructive surgery as a result of an accidental bodily injury, perform reconstructive surgery following neoplastic (cancer) surgery, reconstruct the breast following mastectomy, perform surgery and reconstruction of the other breast to produce symmetrical appearance, cover prostheses and physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the treating Physician and patient, remove breast implants if deemed Medically Necessary and reconstructive breast surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removals of the implants are covered if Medically Necessary, even if the original implant was for cosmetic reasons. Reduction mammoplasty is not covered except when Medically Necessary.

Counseling

Psychiatric or psychological services in the nature of family counseling, marriage counseling, group therapy, sexual counseling or any self-therapy.

Custodial care

Services or supplies provided for Custodial Care.

Day Services

Day Services are not a Covered Service.

Dental Services and Supplies

Any services or supplies incurred for dental care and treatments, dental surgery, or dental appliances, except as provided under Covered Oral Surgery.

Dilation of Nasal Sinus Ostia

Nasal sinus endoscopy with dilation of maxillary, frontal and/or sphenoid sinus ostia is not a Covered Service.

Dietary Services and Supplies

Any services or supplies provided for dietary and nutritional services, except as may be provided under preventive care services, or Covered Services, Dietary and Medication Adherence Services.

Durable Medical Equipment

Non-covered Durable Medical Equipment includes, but is not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.

Education and training

Charges for any type of education or training, including those for learning disabilities except for autism as described under Autism.

Educational or vocational testing. Services for Educational or vocational testing or training.

Elective Abortion

Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, there is a diagnosed fetal abnormality, or the Pregnancy is the result of a criminal act such as rape or incest.

Environmental Sensitivity Services or Supplies

Erectile Dysfunction-Psychological/Psychogenic

It is the use of procedures, supplies, or medications for treatment of psychological/ psychogenic male sexual or erectile dysfunction/impotence.

Excess charges

The part of an expense for care and treatment of an illness or injury that is in excess of the Maximum Allowable Charge subject to Network Adequacy.

Experimental

Investigational services and supplies and all related services and supplies, except for routine patient care costs associated with treatment if those services or supplies would

otherwise be covered under the Plan if not provided in connection with an approved clinical trial program.

Eyeglasses and Lenses

Any services or supplies provided for the correction of vision deficiencies, including, but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, eye refraction, photo reflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except as explained in Covered Services under Eyeglasses and Lenses.

Foreign Travel

Any services and supplies provided to a Covered Individual incurred outside the United States whether the Covered Individual traveled to the location for the purposes of receiving medical services, supplies, or drugs or received those services while traveling for other purposes except for approved international travel for treatment requiring specialty medications as specified under “Specialty Medications” pages 38-39 of this Benefits Plan.

Government Coverage

Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

Hair Loss

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

Hospital Admission for Outpatient Services

Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the participant’s physical condition or the quality of medical care provided.

Hospital Employees

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

Hypnotherapy

Hypnotherapy is not a Covered Service.

Illegal acts

Charges for services received as a result of Injury or Illness occurring directly or indirectly, as a result of a Serious Illegal Act committed by the Covered Individual. For purposes of this exclusion, the term "**Serious Illegal Act**" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from a Mental Disorder.

Immediate Family Covered Individual

Services, supplies, care, or treatments that are rendered by a Covered Individual of the immediate family or person residing in the same household.

Incurred by Other Persons

These are services, supplies, care, or treatment expenses actually incurred by other persons.

Infertility

Any services or supplies provided for, in preparation for, or in conjunction with:

- Sterilization reversal (male or female);
- In vitro fertilization; and
- Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

Long Term Acute Care Facility

Care in a Long Term Acute Care Facility.

Marital or Pre-Marital Counseling

This is the care and treatment for marital or pre-marital counseling.

Medical Social Services

Any services or supplies provided for any medical social services (except as provided as an extended care expense, bereavement counseling (except as provided under hospice care) and vocational counseling.

Medically Necessary/ Medical Necessity

Services, supplies, care or treatment that are not Medically Necessary are not covered.

Mouth Wash

Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

Negligence

For injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any licensed Physician.

Neurofeedback, Biofeedback, Neurotherapy and/or Neurobiofeedback

These are behavior training using brain electrical monitoring and similar programs.

Neurotomy

Dorsal rhizotomy, Thoracic neurotomy, SI joint neurotomy. Dorsal root ganglionectomy

or Transection or avulsion of other extradural spinal nerves.

No Charge

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

Non-Compliance

All charges in connection with treatments or medications where the patient either is in noncompliance with, or discharged from, a Hospital or Skilled Nursing Facility against medical advice.

Non-Emergency Hospital Admissions on Friday or Saturday

Care and treatment billed by a Hospital for Non-Emergency Admissions on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of Admission.

Non-Traditional

Non-traditional medical services, treatments, and supplies that are not specified as covered under this Plan.

No Obligation to Pay

Charges incurred for which the Plan has no legal obligation to pay.

No Physician Recommendation

Care, treatment, services, or supplies not recommended and approved by a Physician; or treatment, services, or supplies when the Covered Individual is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the illness or injury.

No-Show for Appointments, Forms, and Medical Records

Any charges resulting from the failure to keep a scheduled visit with a physician or other professional provider; or charges for completion of any insurance forms; or charges for acquisition of medical records except as needed to administer the Plan.

Obesity

Any services or supplies provided for reduction of obesity or weight, including surgical procedures, except: when Medically Necessary for the treatment of morbid obesity and covered under the Plan.

Occupational

Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Worker's Compensation law. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not parts of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

Orthotics

Any items that include, but are not limited to orthodontic or other dental appliances; splints or bandages available for purchase over-the-counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or

affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

Outpatient Drugs

Are drugs prescribed for outpatient use except administered in a physician's office, purchased directly at an in-network pharmacy, or purchase is approved by ACTIN.

Personal Comfort Items

Personal comfort items or other equipment, including air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood-pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first aid supplies and non-Hospital adjustable beds.

Private-Duty Nursing

These are charges in connection with care, treatment or services of a private-duty nurse.

Prosthetics

A wig or hairpiece is not considered a prosthetic appliance. Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the Covered Individual's responsibility.

Psychologic/Psychogenic Male Sexual or Erectile Dysfunction

Related Provider

Any services or supplies provided by a person who is related to the Covered Individual by blood or marriage.

Replacement Braces and Prosthetics

Replacement of braces if the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Individual's physical condition to make the original device no longer functional. Replacement prosthetic appliances are not covered except those necessitated by growth due to maturity of the Covered Individual.

Residential Treatment Center

Care in a Residential Treatment Center is not a Covered Service.

Any services or supplies in connection with:

- Routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease; or
- Foot care for flat feet, fallen arches, and chronic foot strain.

Routine Eye Examination

Routine Eye Examinations are not a Covered Service.

Services Before or After Coverage

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

Sex changes: Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, and surgery, medical or psychiatric treatment.

Services for Convenience

Services or supplies used primarily for patient convenience.

Sex Change

Transsexual or sex change surgery is not a Covered Service.

Subrogation, Reimbursement, and/or Third Party Responsibility

These are charges for an illness or injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Supplies without a Prescription

These are supplies available for purchase over-the-counter without a doctor's prescription except diabetic supplies outlined under Covered Services.

Telephone calls

Telephone calls between physicians or other health care providers and telephone call discussions between a physician or other health care provider and a patient.

Temporomandibular Joint

Any services or supplies provided for the non-surgical and/or non-diagnostic treatment of, or related to services to, the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery.

Termination

Any services or supplies provided before the patient is covered as Covered Individual hereunder or any services or supplies provided after the termination of the Covered Individual's coverage

Transportation

Transportation or ambulance services because they are more convenient for the patient than other modes of transportation whether or not recommended by a physician or other professional provider except as outlined under Covered Services.

Travel or Accommodations

Charges for travel or accommodations, whether or not recommended by a Physician, except as described in the Medical Benefits Schedule.

Unapproved Out-of-Network Services and Supplies

Services by an out-of-network physician without Pre-Authorization are not Covered Services. The Plan has no obligation to pay for non-approved, out-of-network services or supplies without Pre-Authorization of any kind, except in emergencies.

War

Any services or supplies provided for injuries sustained:

- As a result of war, declared or undeclared, or any act of war.
- While on active or reserve duty in the armed forces of any country or international authority.

ARTICLE VI

WELLNESS PROGRAM

ACTIN's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including

the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If a Member chooses to participate in the wellness program the Member will be asked to complete a voluntary Annual Health Check, one component of which is series of questions about the Member's health-related activities and behaviors and whether the Member has or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

As part of the Member's Annual Health Check the Member will also be asked to complete a biometric screening, which will include blood tests to detect Hepatitis C, high cholesterol, low blood count, kidney and liver disease, diabetes and pre-diabetes, thyroid disease, and tobacco use. The Member's height, weight, waist circumference and blood pressure will also be measured. The Member is not required to complete the Annual Health Check or to complete an Annual Visit with the Member's Primary Care Provider. However, employees and spouses who choose not to complete the Annual Health Check and Annual Examination within 3 months of the start of the Plan Year will be required to pay an additional 10% of the insurance premium above the amount they pay in the first six months of the Plan Year for the second six months of the Plan Year. Employees and Spouses who have completed their initial Annual Health Check and Annual Visit with their Primary Care Provider upon first enrollment in the Plan and who are less than 35 years of age are not liable for any Penalty if they do not complete the Annual Health Check or Annual Visit with their PCP

Employees and spouses who answer the Annual Health Check that they smoke or who test positive for smoking (serum cotinine >15 ng/ml) at the Annual Health Check may avoid a Penalty of an extra 10% of the insurance premium for the second six months of the Plan Year in two ways:

1) Provide a signed letter from the Member's PCP that they have stopped smoking
2) Provide a signed letter from the Member's PCP that they have participated in at least 3 counseling sessions about smoking cessation with their PCP.

Employees and spouses who are diabetic as determined by an A1C of >6.5% on the Annual Health Check may avoid a Penalty of an extra 10% of the insurance premium for the second six months of the Plan Year in two ways:

1) Achieve at least one A1C of <8% within 6 months of the start of the Plan Year
2) Complete 3 counseling sessions with an ACTIN Staff Member or a diabetic counselor.

If a Member is unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, the Member may be entitled to a reasonable accommodation or an alternative standard.