2024 Medical/Prescription Drug, Critical Illness, Accident Insurance and Hospital Indemnity Plans Summary Plan Description

BIMBO Bakeries USA

BIMBO QSR

CLICK THESE TABS TO LEARN MORE

Table of Contents

Bimbo Bakeries USA (BBU) and Bimbo QSR (the "Company") is committed to offering you competitive and valuable benefits. The Company's Medical/Prescription Drug Plan provides comprehensive health care coverage and access to an extensive network of Providers. The Critical Illness, Accident Insurance and Hospital Indemnity Insurance Plans provide added financial protection, in addition to your Company medical coverage, if you or a covered dependent is diagnosed with a critical illness, you suffer a covered accident, or have a qualified hospitalization.

Medical Plan Benefits

The Company offers two medical benefit options under the Medical Plan (Plan) — the Standard HSA and the Enhanced HSA. Both options are administered by Blue Cross and Blue Shield of Illinois (BCBSIL) with the pharmacy benefit managed by Express Scripts. Both options have the same overall plan design with a Company-funded and optional associate-funded Health Spending Accounts (HSAs) and Out-of-Pocket Maximum. In-Network Preventive Care is covered at 100%. The key difference between the plans are the Deductible and Coinsurance amounts.

You choose the option that is right for you and your eligible dependents, or you may waive medical coverage altogether. If you choose to waive medical coverage, you cannot enroll until the next Annual Enrollment period unless you become eligible for HIPAA special enrollment rights or have a qualifying life event as described in the *Family Status Change* section in the Administrative Summary Plan Description (SPD) for the Bimbo Bakeries USA Health & Welfare Plan (Administrative SPD).

Glossary
Certain capitalized terms appear throughout this SPD that have specific meanings as they relate to the Plan. These terms are defined in the *Glossary* starting on **page 48**.

Administrative SPD
The Medical/Prescription Drug, Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance Plans benefits described in this SPD are offered under the Bimbo Bakeries USA Health & Welfare Plan. Additional information, including eligibility, cost of coverage, administrative and legal information about the Medical/Prescription Drug, Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance Plans is described separately in the Administrative SPD. This SPD and the Administrative SPD should be read together.

This SPD outlines provisions of the Company Medical/Prescription Drug, Critical Illness, Accident Insurance and Hospital Indemnity Insurance Plans as of January 1, 2024. The Company reserves the right to change, amend, suspend, or terminate any or all of the benefits under these Plans, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any associate. Nothing in the legal Plan documents or in the SPDs gives any associate the right to be employed by the Company or to interfere with the Company's right to discharge any associate at any time.

Notwithstanding any other provision in this SPD, the Company intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, the Company will modify this SPD accordingly and/or provide a Summary of Material Modifications.

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or are treated by an out-of-network provider at an In-Network hospital, hospital outpatient center, critical access hospital, or ambulatory surgical center, you are protected from surprise billing or balance billing. The **No Surprises Act Final Rules** require certain group health plans to disclose on a public website information about your protections against surprise billing. Please carefully review this "Your Rights and Protections Against Surprise Medical Bills" notice.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for Emergency services and certain services at an In-Network hospital or ambulatory surgical center

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's In-Network cost-sharing amount (such as coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

When you receive services from an In-Network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you receive other services at these In-Network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (e.g., Coinsurance and Deductibles that you would pay if the provider or facility was In-Network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services received from out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an In-Network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and Out-of-Pocket Maximum.

If you believe you've been wrongly billed, you may send complaints about potential violations of federal or state law to:

- The U.S. Department of Health & Human Services at **1-800-985-3059** or **Consumers: protections against surprise medical bills, CMS**.
- Your state agency, which can be located through the **State Consumer Assistance Programs, CMS website.**

You can also review the **No Surprises Billing notice for BCBSIL** to learn more.

Transparency in Coverage — Machine-Readable Files

The **Transparency in Coverage Final Rules** require certain group health plans to disclose on a public website information regarding covered items and services for both In-Network provider rates and historical out-of-network allowed amounts and billed charges in two separate machine-readable files (MRFs). This requirement arises under the amendment of the Public Health Service Act under the "Health Care Prices Revealed and Information to Consumers Explained Transparency Act," also known as the "Health Care PRICE Transparency Act."

You can access the **MRFs for BCBSIL**.

How the Company Medical Plan Works

Both Plan options, which include Prescription Drug coverage, are designed to encourage you to take an active role in all of your health care decisions. You select a Provider — either In-Network or out-of-network — each time you need care. Your out-of-pocket costs are less when you receive care In-Network because the Plan pays a greater percentage of the cost and you are charged lower discounted fees.

In addition to your paycheck contributions, you will incur additional expenses when you use the Plan. For non-Preventive Care services, you must satisfy your Plan option's Deductible before the Plan pays any medical benefits for services provided in that calendar year. You can use your HSA to cover a portion of these costs and pay the remaining costs out-of-pocket. When you reach the Deductible, the Plan pays a specified percentage of the cost of each Covered Service. Any unused amounts in the HSA at the end of the year roll over to the next Plan year. Rollover amounts increase HSA amounts for the following year, and decrease Member Responsibility.

Preventive Care

Part of being healthy in the long run is to stay healthy now through services like immunizations and annual physicals. That's why the Plan pays eligible preventive services at 100% — with no Deductible, no deductions from your HSA, and no annual limit.

When is it not preventive care?

Preventive Care	Not Preventive Care
• Reviewing your current health • Determining existing health risks based on examinations and lab tests	• Reviewing a new medical issue • Testing for new health risks or conditions • Treating a chronic condition

While your preventive care exam is covered 100% by your Company medical plan, you may need to pay based on your medical plan for any non-preventive care services received during your appointment — like talking to your doctor about another health issue that's been bothering you.

Talk to your doctor up front to avoid confusion later:
- Before we talk about this or you take this next step, can you tell me if it's preventive care?
- Can you help me understand if this exam, test, etc. is coded as preventive?

Remember, payment of claims is determined by the diagnostic code supplied by the provider at the time of service. Talk to your doctor to ensure your care is "coded" correctly when the claim is submitted to BCBSIL.

For questions about eligible Preventive Care, contact BCBSIL at **1-877-239-7449** or **bcbsil.com**.

Note: If you use an out-of-network Provider for Preventive Care services, you are responsible for paying any charges above Reasonable and Customary (R&C) Charge limits (see **page 54** for a definition of R&C Charge) for those services. These charges will not apply to your Deductible or annual Out-of-Pocket Maximum. **The Plan will not pay benefits for immunizations received from an out-of-network Provider.**

Adult Preventive Care (after age 18)

Exams, office visits and immunizations, including:

- exercise interventions to prevent falls in adults age 65 years and older who are at increased risk for falls
- physical activity counseling for adults who are overweight or obese and have additional risk factors for cardiovascular disease
- aspirin use for prevention of cardiovascular disease for certain ages
- immunization vaccines, as recommended: hepatitis A, hepatitis B, herpes zoster (shingles), COVID-19, HPV (human papillomavirus), influenza (flu shot), MMR (measles, mumps and rubella), meningococcal, pneumococcal, DtaP (tetanus, diphtheria and pertussis) and varicella

Screenings, including:

- abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
- unhealthy alcohol and drug use screening and counseling
- clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
- syphilis screening for adults at higher risk
- hepatitis B virus screening for persons at high risk for infection
- lung cancer screening in adults age 50 and older who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years

- low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults age 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
- tuberculin testing for adults 18 years or older who are at risk of tuberculosis
- whole body skin examination for lesions suspicious for skin cancer
- obesity screening and counseling
- blood pressure screening
- tobacco use screening and cessation interventions for tobacco users
- cholesterol screening for adults of certain ages or at higher risk
- colorectal cancer screening for adults over age 45
- depression screening
- screening for abnormal blood glucose and type 2 diabetes as part of cardiovascular risk assessment in adults who are overweight or obese
- sexually transmitted infections counseling
- hepatitis C virus (HCV) screening of infection in adults aged 19 to 79 years
- HIV screening for all adults at higher risk
- HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition including baseline and monitoring services

Preventive Care Services for Women (including pregnant women)

Exams, office visits, well-women visits to obtain preventive services and immunizations, including:

- BRCA counseling about genetic testing for women at higher risk
- breast cancer chemoprevention counseling for women at higher risk
- breastfeeding comprehensive lactation support and counseling from trained Providers, as well as access to breastfeeding supplies for pregnant and nursing women; electric breast pumps are limited to one per benefit period
- FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs
- IUD (intrauterine device) services related to follow-up management of side effects, counseling for continued adherence and device removal
- aspirin use for pregnant women to prevent preeclampsia
- behavioral counseling to promote healthy weight gain during pregnancy
- behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older
- STI (sexually transmitted infections) counseling

Screenings, including:

- bacteriuria urinary tract screening or other infection screening for pregnant women
- cervical cancer screening
- chlamydia infection screening for younger women and those at higher risk
- domestic and interpersonal violence screening and counseling
- daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
- gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk
- gonorrhea screening
- hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling
- osteoporosis screening for women over age 65, and younger women with risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
- syphilis screening for pregnant women and those at increased risk
- perinatal depression screening and counseling
- diabetes screening after pregnancy
- human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
- urinary incontinence screening
- breast cancer mammography screening, including breast tomosynthesis and, if Medically Necessary as determined by a Physician, Advanced Practice Nurse or a Physician Assistant, a screening MRI and comprehensive ultrasound
- screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy

Preventive Care Services for Children

Exams, office visits and immunizations, including:

- alcohol and drug use assessment for adolescents
- behavioral assessments for children of all ages
- fluoride chemoprevention supplements for children without fluoride in their water source
- fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption
- tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
- gonorrhea preventive medication for eyes of all newborns
- height, weight and body mass index measurements
- iron supplents for children ages 6 to 12 months at risk for anemia
- medical history for all children throughout development
- oral health risk assessment for children up to 6 years old
- STI (sexually transmitted infections) prevention and counseling for adolescents
- immunization vaccines from birth to age 18, as recommended: hepatitis A, hepatitis B, HPV (human papillomavirus), influenza (flu shot), MMR (measles, mumps and rubella), mengiococcal, pneumococcal, COVID-19, DtaP (tetanus, diphtheria and acellular pertussis), varicella, haemophilus influenza type b, rotavirus, inactivated poliovirus and any other immunization required by law. **Note:** Allergy injections are not considered immunizations.
- counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer

Screenings, including:

- autism screening
- blood pressure
- cervical dysplasia for sexually active females
- congenital hypothyroidism for newborns
- critical congenital heart defect screening for newborns
- bilirubin screening in newborns
- depression for adolescents
- development screening for children under age 3 and surveillance throughout childhood
- dyslipidemia for children ages 9-11 and 17-21
- hearing screening for newborns, children and adolescents
- hematocrit or hemoglobin
- hemoglobinopathies or sickle cell for newborns
- HCV (hepatitis C virus) for those at risk
- HIV for adolescents at higher risk
- lead screening for those at risk
- obesity screening and counseling
- PKU (phenylketonuria) for newborns
- vision screening
- newborn blood screening
- whole body skin examination for lesions suspicious for skin cancer
- tuberculin testing for children at higher risk

Preventive Drug Program:

Through the Preventive Drug Program administered through Express Scripts, certain Outpatient prescriptions and medicines are covered at 100% of the Eligible Charge. You receive Plan benefits whether you purchase your eligible preventive drug from an In-Network or out-of-network Provider.

The program includes Outpatient Prescription Drugs in the following categories: anti-angina, anti-arrhythmics, anti-coagulants/anti-platelets, anti-malarial, breast cancer prevention, contraceptives, diabetes – hypoglycemic agents, insulin and oral, fluoride supplements, heparins/low molecular weight heparin, high blood pressure, high cholesterol, infant eye ointment (for newborns), osteoporosis, prenatal vitamins, respiratory, tobacco cessation and vaccines.

For additional information about specific drugs included in the Preventive Drug Program, call Express Scripts member services at **1-866-544-2941**.

Wellness Care (age 16 and older)

The Plan pays eligible Covered Services at 100% — with no Deductible, no deductions from your HSA, and no annual limit — when you use an In-network Provider.

Benefits will be limited to the following services:

- Routine diagnostic medical procedures
- Routine laboratory tests
- Routine EKG
- Routine X-ray
- Routine ovarian cancer screening
- Routine colorectal cancer screening X-ray
- Routine digital rectal examinations and prostate tests

Health Savings Account (HSA)

If you enroll in Company medical coverage, you may contribute to an HSA. An HSA is a tax-advantaged account that gives you more control over your health care dollars. You can use an HSA to pay for eligible health care expenses now and in the future — even in retirement, including Medicare premiums once you reach age 65. This account works like a savings account, so the funds in your HSA will roll over from year to year — even if you drop Company medical coverage or leave the company.

You don't pay taxes on any money up to the IRS contribution limits that you put into your HSA, when it goes into your account or when you use it for eligible expenses. Your HSA dollars earn interest, and those earnings are tax-free too if used for eligible medical expenses. The Company will make a lump-sum contribution annually to your HSA at the beginning of each year or when you become eligible. You can choose to fund your account by contributing before-tax dollars via payroll.

Per the IRS, for 2024, the maximum amount you can contribute to an HSA is $4,150 for individual coverage and $8,300 for family coverage if you are enrolled in a high deductible health plan. If you are age 55 or older in 2024, you can make a catch-up contribution of $1,000 to your HSA. These contribution limits include any contributions made by you, the Company or anyone else on your behalf. **Note:** If you enroll in Company medical coverage, you cannot enroll in a general purpose Health Care Flexible Spending Account.

Member Responsibility

You can use your HSA rollover funds from prior years, if any, to contribute toward your Member Responsibility portion of the Deductible. If you exhaust your HSA during the Plan year, you are responsible for paying out-of-pocket for remaining Covered Expenses until you reach the Deductible. The amount you need to pay — your Member Responsibility — depends on the option and coverage level you selected. (See *Coverage Levels* on **page 10** for specific amounts for each option.)

Deductible

The Deductible is the total amount you pay before you begin to pay Coinsurance. Coinsurance is the percentage of the cost of care that you pay. Your HSA and your Member Responsibility are used to meet your Deductible for the year. If you cover your spouse and/or any dependent children, you must meet the full Deductible for your coverage level before the Plan pays Coinsurance for any person. Your Deductible depends on the option and coverage level you choose.

Note: Many Covered Expenses reimbursed through your HSA or paid by you as your Member Responsibility will count toward your Deductible. Some expenses do not apply to your Deductible, such as:

- expenses that aren't covered by the Plan;
- amounts above Plan limits; and
- out-of-network charges above R&C Charge limits

Coinsurance

After you have paid your Deductible in full, you and the Company share the cost of Covered Expenses for the year through Coinsurance. Your Coinsurance will vary depending on the Plan option you elect and whether you choose to receive care In-Network or out-of-network:

Coinsurance (after Deductible, until Out-of-Pocket Maximum is met)	Standard HSA		Enhanced HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
The Plan pays	70%	50%	80%	60%
You pay	30%	50%	20%	40%

**For out-of-network care, the Plan pays a percentage of Reasonable and Customary (R&C) Charges. You pay the remaining percentage, up to the Out-of-Pocket Maximum, plus any amounts above R&C Charges.*

See **page 12** for cases where Coinsurance amounts may differ. For example, emergency room care and ambulance services are generally covered at the In-Network level of benefits regardless of where services are received. (See *Glossary* on **page 54** for an explanation of R&C Charges.)

Out-of-Pocket Maximum

Your Out-of-Pocket Maximum depends on the option and coverage level you choose, as well as whether you receive In-Network or out-of-network care. (See Coverage Levels on **page 10** for specific amounts for each option.) You reach your Out-of-Pocket Maximum when you have paid (through Deductible and Coinsurance payments) the applicable maximum amount according to your Plan option and coverage level. Once you reach the Out-of-Pocket Maximum, the Plan pays 100% of eligible medical and prescription drug expenses for the remainder of the year. If you cover your spouse and/or any dependent children, no individual family member will pay more than $6,000/In-Network and $12,000/out-of-network for out-of-pocket expenses in 2024.

The following charges do not count toward your Out-of-Pocket Maximum:

- amounts in excess of out-of-network R&C Charge limits (see *Glossary* on **page 54** for a definition of R&C Charges)
- any payment to a Provider in excess of the amount agreed upon by the Provider and BCBSIL for a particular service
- charges beyond Plan or benefit maximums
- expenses not covered by the Plan
- Prescription Drug costs if you choose not to use the mail-order pharmacy to get your medication. (You may get up to one fill and two refills of Prescription Drugs at a retail pharmacy. After that, the Plan will not cover your prescription at a retail pharmacy, nor will the cost apply toward your Deductible or Out-of-Pocket Maximum. **Note:** You will receive information from Express Scripts on how to switch to mail-order, or how to fill 90-day prescriptions for maintenance/long-term medications at Walgreens, for your prescription to continue to be covered by the Plan.)

Coverage Levels

As described earlier, the coverage level and Plan option you choose determine:

- the amount the Company credits to your HSA
- your Deductible (In-Network and out-of-network)
- your Coinsurance level (In-Network and out-of-network)
- your Out-of-Pocket Maximum (In-Network and out-of-network)

See the chart for complete details:

Coverage Level		Standard HSA	Enhanced HSA
You Only	Deductible*	In-Network: $3,000 Company's HSA contributions: $550 Member Responsibility: $2,450 Out-of-network: $6,000	In-Network: $2,000 Company's HSA contributions: $750 Member Responsibility: $1,250 Out-of-network: $4,000
	Coinsurance	**You Pay:** In-Network: 30% Out-of-network: 50%	**You Pay:** In-Network: 20% Out-of-network: 40%
	Out-of-Pocket Maximum**	**You Pay:** In-Network: $6,000 Out-of-network: $12,000	**You Pay:** In-Network: $6,000 Out-of-network: $12,000
You + Family	Deductible*	In-Network: $6,000 Company's HSA contributions: $1,100 Member Responsibility: $4,900 Out-of-network: $12,000	In-Network: $4,000 Company's HSA contributions: $1,500 Member Responsibility: $2,500 Out-of-network: $8,000
	Coinsurance	**You Pay:** In-Network: 30% Out-of-network: 50%	**You Pay:** In-Network: 20% Out-of-network: 40%
	Out-of-Pocket Maximum**	**You Pay:** In-Network: $12,000 Out-of-network: $24,000	**You Pay:** In-Network: $12,000 Out-of-network: $24,000

**All Eligible Charges count toward the Deductible and both In-Network and out-of-network Out-of-Pocket Maximums.*

***There will be an Out-of-Pocket Maximum for each individual family member enrolled in You + Family coverage. For example, the Out-of-Pocket Maximum under Standard HSA for You + Family is $12,000/In-Network and $24,000/out-of-network; however, no individual family member enrolled in this coverage will pay more than $6,000/In-Network and $12,000/out-of-network for out-of-pocket expenses in 2024.*

How the Plan Pays Benefits

The following shows how the Plan pays benefits for Covered Expenses. Out-of-network benefits are generally based on Reasonable and Customary (R&C) Charge limits for Covered Services; you pay charges above R&C Charge limits if you use out-of-network Providers. Please note that this chart is representative of many services covered under the Plan (not all services). For more details, see *What's Covered* on **page 15** or access complete Plan details at **myBBUBenefits.com**.

	Standard HSA		Enhanced HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Preventive Care				
Routine Preventive Care for Children and Adults (including routine immunizations)	100%, no Deductible		100%, no Deductible	
Immunizations				
Routine Mammograms, PSA, Pap Smear				
Physician Services				
Physician Office Visit	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Telemedicine	You pay $48. After meeting Deductible, Plan pays 70%	Not available	You pay $48. After meeting Deductible, Plan pays 80%	Not available
Surgery Performed in the Physician's Office	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Allergy Treatment/Injections	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Allergy Serum (dispensed by the Physician in the office)	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Emergency and Urgent Care Services				
Hospital Emergency Room	70% after Deductible	70% after Deductible	80% after Deductible	80% after Deductible
Non-Emergency Services Received in the Emergency Room	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Urgent Care Visit	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Ambulance	70% after Deductible	70% after Deductible	80% after Deductible	80% after Deductible

For out-of-network care, the Plan pays a percentage of R&C Charges. You pay the remaining percentage, up to the Out-of-Pocket Maximum, plus any amounts above R&C Charges. See **page 54 for complete definition of R&C Charge and **page 52** Maximum Allowance.*

Chart continued on next page

	Standard HSA		Enhanced HSA	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Other Services				
Inpatient Hospital Care	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Outpatient Hospital Care	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Surgery	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Maternity care	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Independent Laboratory and X-Ray Services	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Inpatient Psychiatric Care and Substance Abuse Treatment	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Outpatient Psychiatric Care and Substance Abuse Treatment (no visit limit)	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Skilled Nursing Facility Care (up to 120 days per participant for each Plan year; In-Network and out-of-network combined)	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Home Health Care	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Hospice Care (if pre-certified)	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Acupuncture	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Chiropractic, Speech, Physical and Occupational Therapy (includes chiropractic services; up to 60 visits per participant per Plan year; combined visit limit for all treatments); In-Network and out-of-network combined	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Mastectomy Coverage	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Inpatient Rehabilitation (no visit limit when managed by medical necessity)	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible

For out-of-network care, the Plan pays a percentage of R&C Charges. You pay the remaining percentage, up to the Out-of-Pocket Maximum, plus any amounts above R&C Charges. See **page 54 for complete definition of R&C Charge and **page 52** Maximum Allowance.*

***See **page 51** for a description of what is considered a Hospital under the Plan, **page 52** for a definition of Inpatient, and **page 53** for a definition of Outpatient.*

Precertification

Before receiving certain services or obtaining certain supplies or Durable Medical Equipment as listed below, you must call BCBSIL. It is your responsibility as the Plan participant — not your Provider's — to call for Precertification to receive the best Medically Necessary care in the most appropriate facility. Precertification is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. Contact BCBSIL at **1-877-239-7449** for:

- **All Inpatient admissions.** This includes anytime you are admitted for an overnight stay including Hospital, rehabilitation, Hospice, Skilled Nursing and mental health facilities. You or a family member should contact BCBSIL within 24 hours of an acute or unexpected admission — or seven days before planned or elective admissions (or as soon as you know of the admission). Admissions requiring Precertification include, but are not limited to:
  - back/spine surgery
  - cardiac, pulmonary and vestibular rehabilitation
  - gastric bypass
  - hysterectromy
  - oral surgery/TMJ
  - rhinoplasty, blepharoplsty, orthognathic surgery
  - uvulopharyngopalatoplasty

- **Certain Outpatient procedures.** You are encouraged to notify BCBSIL of the following procedures as soon as you know they will be performed. To verify coverage for these procedures it is recommended that you have your Physician submit a predetermination of benefits. Procedures include, but are not limited to:
  - PET Scans/MRIs/MRAs/MRSs/CTs or CAT scans
  - imaging cardiac stress tests
  - home IV infusion therapy
  - heart cauterization

- **Cosmetic or reconstructive procedures.** You are encouraged to notify BCBSIL of the following procedures as soon as you know they will be performed. To verify coverage for procedures it is recommended that you have your Physician submit a predetermination of benefits. **Note:** As a general rule, the Plan does not cover cosmetic or reconstructive procedures unless determined to be Medically Necessary. Procedures include, but are not limited to:
  - skin removal or enhancement
  - lipectomy
  - breast reduction
  - breast enlargement
  - surgery for gynecomastia
  - treatment of varicose veins
  - specific eye, ear and nose procedures, or erectile dysfunction

- **Durable Medical Equipment.** For Durable Medical Equipment, you must notify BCBSIL as soon as you know the equipment is needed. To verify coverage for equipment it is recommended that you have your Physician submit a predetermination of benefits. Equipment includes, but is not limited to:
  - cervical traction
  - crutches
  - insulin pumps
  - IV equipment
  - lite weights
  - nonspecific custom equipment
  - NM and bone stimulators
  - percussors
  - portable oxygen or liquid oxygen systems
  - POV
  - pressure appliances
  - specialty beds and mattresses
  - speech generating devices
  - TENS unit
  - ultrasonic equipment
  - UV lights
  - wheelchairs and accessories
  - wound vac systems

- **External prosthetic appliances.** For external prosthetic appliances, you must notify BCBSIL as soon as you know the equipment is needed. To verify coverage for equipment it is recommended that you have your Physician submit a predetermination of benefits. Equipment includes, but is not limited to:
  - braces
  - custom fabricated molded knee braces (sports grade)
  - custom molded cranial bands
  - molded or premolded foot/arch supports
  - orthotics
  - prosthetic devices
  - splints
  - unspecified orthotics

- **Home health care.** You must notify BCBSIL before you receive home health care services, including home infusion.

- **Other care.** To verify coverage for other types of non-emergency care it is recommended that you have your Physician submit a predetermination of benefits. Other care includes, but is not limited to:
  - biofeedback
  - occupational therapy
  - speech therapy

Denial of Request for Precertification

If your request for Precertification is denied, you will be notified in writing.

Precertification for Childbirth

Hospital maternity stays in excess of 48 or 96 hours as specified in *What's Covered* on **page 15** must be precertified. The Plan generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, or require that a health care Provider obtain authorization from the Plan or any insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Concurrent Review

After admission to the Hospital, BCBSIL will continue to evaluate the Covered Person's progress through concurrent review to monitor the length of admission and medical necessity of treatment. If BCBSIL disagrees with the length of admission recommended by the Physician, the Covered Person and the Physician will be advised. If it is determined that continued admission is no longer Medically Necessary, additional days will not be certified.

Alternative Care

BCBSIL may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not Covered Expenses under this Plan.

The recommended alternatives will be considered as Covered Expenses under the Plan provided the expenses can be shown to be viable, Medically Necessary, and are included in a written case management report or treatment plan proposed by BCBSIL. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person or any other Covered Person. You may voluntarily choose, but are not required to select, the recommended alternative care.

What's Covered

The Plan provides benefits for Covered Expenses (that is, medical services and supplies and Prescription Drugs that are considered Covered Services). A Covered Provider must deliver or direct the services and supplies.

In most cases, the level of benefits you receive depends on whether you receive care from an In-Network Provider or out-of-network Provider. In some cases, your coverage is the same no matter where you receive care. Read each of the following sections carefully for specific information about what is covered.

Protections From Surprise Medical Bills

The surprise billing provisions of the No Surprises Act provides protections from surprise medical bills for:

- coverage of emergency services performed by an out-of-network provider
- coverage of non-emergency services performed by an out-of-network provider at an In-Network facility
- medical transport services (by helicopter or airplane) received from an out-of-network provider if the services would have been covered if received from an In-Network provider

Emergency Services from an Out-of-Network Provider

Your coverage for emergency services will continue until your condition is stabilized and:

- Your attending physician determines that you are medically able to travel or to be transported, by medical or non-emergency medical transportation, to another provider if you need more care;
- You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services; and
- Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. You can contact BCBSIL or your In-Network Provider or primary care physician.

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an In-Network Provider. The cost share will be based on the median contracted rate. Contact BCBSIL immediately if you receive such a bill.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from an In-Network Provider
- Emergency services

Your cost share for involuntary services will be calculated in the same way as if you received the services from an In-Network Provider. If you received a surprise bill, your cost share will be calculated at the median contracted rate.

Applied Behavioral Analysis (ABA) Therapy

ABA therapy to help children with autism spectrum disorder (ASD), or other developmental conditions, improve social, communication, and learning skills through positive reinforcement is covered subject to copays, coinsurance and deductible. Age, dollar or visit limits do not apply and instead coverage will be based upon specific medical necessity criteria.

Acupuncture

Acupuncture when administered by a licensed Provider.

Allergy Treatment

Allergy injections, testing and serum.

Ambulance

Transport by ground ambulance to and from the nearest facility where you can receive needed medical care. (Air ambulance when it is the only acceptable means of transporting the patient.)

Breast Reconstruction

In compliance with the Women's Health and Cancer Rights Act, if you or a covered dependent receives breast reconstruction services connected with a mastectomy, the Plan covers the following services:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

This coverage is subject to the same Deductible and Coinsurance provisions that apply for any other surgical procedures under the Plan.

Chiropractic Care

Chiropractic care by a licensed chiropractor — including Medically Necessary exams, manipulations, diagnostic X-rays and lab services — is covered up to 60 visits per participant each Plan year (combined with speech therapy, physical therapy and occupational therapy), In-Network and out-of-network combined. See *Speech, Physical and Occupational Therapy* on **page 19** for more information.

Dental Expenses Covered Under the Plan

Dental care, treatment, implants, surgery, or supplies are not covered under the Plan, except for the following:

- repair within six months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan
- Inpatient Hospital and anesthesia expenses related to dental work if the primary reason for the admission is deemed to be an underlying serious and hazardous medical condition
- TMJ (temporomandibular joint syndrome) treatment by a dentist or Physician (excludes orthodontic treatment)

Durable Medical Equipment

Prosthetic devices and Durable Medical Equipment refer to medical equipment provided by a Physician for use outside a Hospital, Skilled Nursing Facility or Inpatient rehabilitation facility. The Plan covers rental (not more than the purchase price) or, if less costly, purchase of Durable Medical Equipment and related supplies including prosthetic appliances and wigs (when needed for hair loss due to cancer or alopecia areata). Durable Medical Equipment does not include orthopedic shoes, supports, arches, inner soles or corn pads. See *Precertification* on **page 13** for more information on Durable Medical Equipment.

Emergency Room Care

If you need emergency medical care and cannot arrange for care from an In-Network Provider, Emergency Services will be covered at the In-Network level — regardless of the Provider's network status. In a true emergency, Emergency Services will be covered In-Network. Once you are able to direct your care, you must use an In-Network Provider to receive the highest level of benefit. (See **page 11** for emergency room benefits.)

People sometimes use emergency rooms to find a Physician at night or because they don't know where else to turn. Emergency room care should be limited to those conditions that require immediate attention to avoid loss of life or serious, accidental injury. In general, a cold, the flu or a sore throat is not considered an emergency and should be treated in a Physician's office or urgent care setting. Benefits for covered non-emergency use of the emergency room will be reduced to 50% of Covered Expenses if the Plan determines that a less intensive (or more appropriate) treatment could have been given in a more appropriate setting than the emergency room.

Home Health Care

Home health care refers to part-time medical assistance by a Home Health Agency that patients can receive at home while recuperating from an illness or accidental injury.

The Plan covers home health care services only when your Physician requires that you receive Skilled Care Services.

Home health care may include:

- intermittent home health aide services
- medical supplies and medicines prescribed by a Physician
- nutritionist services
- part-time or occasional care by a licensed nurse
- physical, occupational, speech and inhalation therapy
- services of a medical social worker

Home health care does not include:

- Custodial Care
- transportation services
- services or supplies furnished while the patient is not under the continuing care of a Physician
- services provided by family members or anyone else who lives with the patient

Home Infusion Therapy

Home infusion therapy when ordered by a Physician, including:

- ancillary medical supplies
- collection, analysis and reporting of lab tests to monitor response to the therapy
- emergency care
- enteral feedings
- nursing services to train you or your caregiver or to monitor the therapy
- pharmacy compounding and dispensing services
- other eligible home health supplies and services provided during home infusion therapy

Hospice Care

Hospice Care refers to services provided for a Terminally Ill person and his/her family members. To be considered "Terminally Ill" a statement from the attending Physician is required, indicating the life expectancy to be six months or less. This care may be instead of Hospital admission.

Benefits include:

- admission in a licensed Hospice Facility or Skilled Nursing Facility
- home Hospice Care provided by an approved Hospice team
- nursing care by or under supervision of a registered nurse
- physical and/or occupational therapy
- medical social services
- home health aide services
- drugs and medical supplies
- counseling (must be given by a licensed counselor)

Hospice Care does not include:

- charges for pastoral, financial or legal counseling
- services not solely related to the care of the covered family member (for example, homemaker or caretaker services, transportation expenses and care provided when the Covered Person's family or usual caretaker cannot attend to the Covered Person's needs)
- charges associated with funeral arrangements

Hospital Room and Board

These expenses include semiprivate Hospital room and board, certain Physician fees, supplies and special services and other miscellaneous Hospital fees. Hospital services must be provided by or through a Physician.

If you choose to stay in a private room, the Plan pays a percentage of the semiprivate room rate. If you require a private room due to a medical condition as determined by your Physician, the Plan pays a percentage of the private room rate. (The attending Physician must submit a letter to BCBSIL explaining the reasons why your condition requires a private room.)

Any charges that exceed the contracted room rate are the patient's responsibility unless:

- the facility did not have any semiprivate rooms available at time of stay
- the facility is in an all-private room facility

If a Provider indicates that a private room is necessary, he/she must provide documentation justifying this to BCBSIL.

Hospital Services

Covered Hospital services include expenses such as:

- anesthesia
- Inpatient drugs and medicines
- Inpatient Physician care
- nursing care
- X-rays and lab tests

Infertility Treatment

Covered infertility services and associated expenses include:

- diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician
- in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)
- embryo transfer
- collection, preparation and storage of donor ovum and semen, and related costs
- artificial insemination

There is a two cycle per participant lifetime maximum for infertility benefits, including medical services/treatment and related Prescription Drug costs; In-Network and out-of-network combined.

The cost of eligible expenses will be applied against your HSA, Member Responsibility or Coinsurance.

Maternity Care

The Plan pays pregnancy-related benefits (including prenatal visits) the same as any eligible medical expense.

Federal law sets the following minimum coverage for Hospital stays for childbirth:

- 48 hours following delivery for vaginal birth, or
- 96 hours following delivery for cesarean section

This minimum length of stay applies to both the mother and newborn; however, the mother and an attending Physician can decide on discharge of the mother or newborn child sooner.

You must enroll the newborn child in the Plan through the BBU Benefits Center within 31 days of birth. See *Making Changes During the Year* in the Company's Plan Administrative SPD for more information about adding a new dependent.

Medical Supplies

Covered medical supplies include:

- blood and blood plasma transfusions
- diabetic supplies and insulin
- orthotics when Medically Necessary following an acute accidental injury or surgery (see *What's Not Covered* on **page 21** for orthotics that are not covered under the Plan)
- oxygen and other gases
- splints, casts and dressings

Prescription Drugs

The Plan covers Prescription Drugs received during an Inpatient admission. See **page 27** for details about coverage for other medications.

Preventive Care

The Plan covers Preventive Care. See **page 5** for details about coverage for Preventive Care.

Professional Services

Benefits include these medical/surgical services:

- circumcision
- cochlear implants
- contraceptive services (e.g., Norplant)
- eye surgery to correct refractive errors (e.g., LASIK) up to $450 lifetime maximum
- genetic testing and counseling
- nutritionist services (when required to treat a medical condition)
- office visits
- Outpatient (ambulatory) surgery
- Outpatient cardiac rehabilitation services
- Physicians' Inpatient Hospital visits
- preadmission testing
- virtual colonoscopy when performed in connection with diagnostic testing only
- vision therapy, provided therapy is rendered in connection with the following visual disorders:
  - amblyopia
  - accommodative disorders
  - ocular motor and visual motor dysfunctions
  - binocular vision disorders (e.g., strabismus)

Psychiatric Care and Substance Abuse Treatment

Psychiatric care must be received in an approved facility from a licensed Provider acting within the scope of his/her license. Substance abuse treatment must be part of a Rehabilitation Program — not just for detoxification. (See *Glossary* on **page 55** for the definition of a Rehabilitation Program.)

- covered Inpatient psychiatric and substance abuse treatment has no limit, whether you receive In-Network or out-of-network care
- covered Outpatient psychiatric care and substance abuse visits have no limit, whether you receive In-Network or out-of-network care

Radiation and Chemotherapy

The Plan covers X-ray, radium, radio and isotope treatments.

Rehabilitation

Rehabilitation services that are expected to result in significant physical improvement in a condition within two months from the beginning of treatment.

Skilled Nursing Care

Skilled nursing care provides quality medical care for patients recovering from an illness or accidental injury or who are being treated for a long-term or Terminal Illness.

Covered Services and supplies include semiprivate room and board, charges for other medical services and supplies, and Physician's services. Skilled nursing care is covered up to a maximum of 120 days per participant per Plan year, In-Network and out-of-network combined. Care must be initiated within 14 days of your or your covered dependent's discharge from an Inpatient Hospital stay (or your discharge from a related Skilled Nursing Facility). Skilled nursing home care does not include treatment for:

- Custodial Care
- substance abuse
- senility
- mental retardation
- any other mental disorder

Speech, Physical and Occupational Therapy

To receive coverage, short-term Outpatient, speech and/or physical therapy must be expected to result in objective, measurable and significant physical improvement within two months from the start of treatment.

Speech therapy, physical therapy, occupational therapy and chiropractic care are covered up to 60 combined In-Network and out-of-network visits per participant per Plan year. The Plan covers services provided by a licensed practitioner when Medically Necessary to treat an illness or accidental injury. Congenital defects or anomalies are covered.

Surgery

Covered Expenses include surgeon's fees, preoperative and postoperative care, and the administrative of anesthesia. If two or more covered surgical procedures are performed:

- through the same incision;
- through separate incisions; or
- in the same operative field the Plan covers the major procedure and then pays reduced benefits for each additional procedure. No additional payments will be made for an incidental procedure performed through the same incision

The Plan also covers surgery for morbid obesity, provided it is determined to be Medically Necessary by your Physician and you meet clinical criteria as determined by BCBSIL. Call BCBSIL at **1-877-239-7449** for information.

Telemedicine

Plan participants have access to MDLive, a telemedicine service that connects you with a board certified Physician 24 hours a day, 365 days a year when you have a non-emergency medical concern or question. You have the option to connect with an MDLive Physician by phone or through video conference appointments. You and your covered dependents are automatically enrolled in MDLive when you enroll for Plan coverage. Call MDLive at **1-888-676-4204** or visit **mdlive.com**. Each consult with MDLive is $48 until you meet your Deductible; then your cost is based on Coinsurance.

Transplants

The following human organ or tissue transplants are covered by the Plan:

- allogeneic and syngeneic bone marrow transplants
- autologous bone marrow transplants
- heart or heart/lung
- liver (cadaver or living)
- lung (single or double)
- pancreas for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
- kidney (cadaver or living)
- cornea
- small bowel

Bone marrow transplants include stem cells from bone marrow, peripheral blood, and umbilical cord blood sources. In addition, the transplant program provides donor coverage for kidney, liver and bone marrow transplants; testing of potential donors; donor evaluation and workup; and Hospital and professional services related to organ procurement. In the case of donors, the Plan will coordinate benefits with the donor's health coverage.

Coverage is limited to two transplant procedures for the same condition per participant per lifetime.

When care is provided by a BCBSIL facility more than 50 miles from the patient's home, the Plan will pay for certain travel and lodging expenses for one person. (If the patient is a minor, both parents will receive travel benefits.) A per diem lodging allowance of $50 per person for the recipient and one companion will be allowed, up to a $10,000 per transplant maximum.

BCBSIL must approve all travel and lodging expenses in advance. Travel and lodging expenses that are not approved in advance will not be paid. This travel benefit is not applicable for non-approved facilities.

Urgent Care

Covered Expenses received at urgent care centers (facilities separate from a Hospital and operated to provide health care services in emergencies or after hours).

Wellness Screening

The Plan covers 100% of the cost of a Wellness Screening when you receive your Wellness Screening from an In-Network Physician during a Preventive Care visit. See *Paying for Your Wellness Screening* on **page 35**.

X-ray and Lab Tests

The Plan covers Outpatient X-rays and lab charges, including mammography.

What's Not Covered

In addition to other limits described in this SPD, and as with all medical benefit plans, the Plan does not cover some expenses, including:

Hospitalization, services and supplies which are not Medically Necessary.

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, considered Medically Necessary.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

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

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

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

- Services or supplies that are not specifically mentioned in this SPD.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war, or an act of war.
- Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.
- Services and supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.

- Investigational services and supplies and all related services and supplies, except as may be provided for (a) the cost of routine patient care associated with investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under the plan if not provided in connection with a qualified cancer trial program and (b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
- Custodial Care service.
- Long Term Care service.
- Respite Care service, except as specifically mentioned under the Hospice Care program.
- Inpatient Private Duty Nursing Service.
- Routine physical examinations, unless otherwise specified in this SPD.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this SPD.
- Services or supplies for intersegmental traction; all types of home traction devices and equipment; vertebral axial decompression sessions; surface EMGs; spinal manipulation under anesthesia; muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and balance testing through computerized dynamic posturography sensory organization test.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this SPD.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.
- Treatment of tissue damage or disease in any location with platelet-rich plasma.
- Immunizations, unless otherwise specified in this SPD.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this SPD.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental disability, except as may be provided under this SPD for Autism Spectrum Disorder(s).
- Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this SPD.
- Hypnotism.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Company medical plan.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are investigational, unless otherwise specified in this SPD.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

- Wigs (also referred to as cranial prostheses), unless otherwise specified in this SPD.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this SPD.
- Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
- Testing of blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels; urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes); and allergen specific IgG measurement.
- Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements, other than those specifically named in this SPD.
- Elective abortions.
- Reversals of sterilization.
- Naprapathic services.
- Any related services to a non-covered service. Related services are (a) services in preparation for the non-covered service; (b) services in connection with providing the non-covered service; (c) hospitalization required to perform the non-covered service; or (d) services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
- Self-administered drugs dispensed by a Physician.
- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this SPD.
- Any of the following applied behavioral analysis (ABA) related services:
  - Services with a primary diagnosis that is not Autism Spectrum Disorder;
  - Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the Glossary section of this SPD;
  - Activities primarily of an educational nature;
  - Shadow or companion services; or
  - Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- for or in connection with a Sickness which is covered under any Workers' Compensation or similar law
- for charges made by a Hospital owned or operated by or which provides care or performs services for the U.S. government, if such charges are directly related to a military service connected condition
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- for charges that the person is not legally required to pay
- to the extent that they are more than either the applicable contracted fee, applicable Reasonable and Customary Charges or applicable scheduled amount
- for charges for unnecessary care, treatment or surgery
- to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- for or in connection with the Experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society
- no payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you or any one of your dependents

BCBSIL: Your Medical Plan Administrator

BCBSIL administers the Company Medical Plan. To help you use the Plan well and stay healthy, you have access to a variety of BCBSIL resources.

Finding Network Providers

When you are covered by the Plan, you will be able to visit any Physician or Hospital you choose. But, you will save money and make the most of your HSA dollars by using In-Network Providers and pharmacies.

Use BCBSIL's Provider Finder® tool to see if a Physician is In-Network. Access this tool at **bcbsil.com** and click *Find a Physician*, or call BCBSIL's Customer Service at **1-877-239-7449**, 9:00 a.m. to 7:00 p.m., Eastern Time, Monday to Friday.

The Company Medical Plan provides personalized digital/electronic ID cards. Along with your personal ID details, these cards include useful reference information such as applicable deductibles and Out-of-Pocket Maximums, along with telephone and Internet contact details to get assistance with your benefits.

To access your personalized Company Medical Plan digital/electronic ID cards, visit **bcbsil.com** and log in (or register for personalized access if you are a first-time user).

Blue Access for Members

Blue Access for Members, BCBSIL's member-only website, gives you immediate and secure access to your benefit information and easy-to-use tools. You can access claim status and history, use wellness tools, print a temporary ID card and find local Physicians. To register for the first time:

- go to **bcbsil.com**
- click on *Member Services*
- click *Register Now*
- use the Company group and identification numbers on your BCBSIL ID card to complete the registration process

If you have questions, contact the BCBSIL Help Desk at **1-888-706-0583**, Monday to Friday, 8:00 a.m. to 11:00 p.m. Eastern Time and Saturday, 8:00 a.m. to 4:00 p.m. Eastern Time.

Continuity of Care and Network Provider Changes
Under federal law effective on and after January 1, 2022, should your provider lose network status under your Company Medical Plan (other than for cause) while you are considered a continuing care patient as defined by the law, you may be permitted to continue coverage for that course of treatment at network cost sharing rates for 90 days after you are notified, or the date on which you are no longer a continuing care patient, if earlier. Contact BCBSIL for additional information.

Before obtaining covered health care services you should verify the network status of a provider to ensure the provider is in your Company Medical Plan's network. A provider's status may change. If you receive a covered health care service from an out-of-network provider and you were informed incorrectly by BCBSIL prior to receipt of the covered health care service that the provider was a network provider, either through BCBSIL's database, provider directory, or BCBSIL's response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from an In-Network Provider under federal law effective on and after January 1, 2022. Contact BCBSIL for additional information.

Managing a Chronic Condition? Lean on a BCBSIL Personal Health Clinician.
If you are currently living with a medical condition, such as chronic obstructive pulmonary disease (COPD) or asthma, a BCBSIL Personal Health Clinician can help you live better and avoid complications. Based on health care claims data, you and/or your enrolled spouse may receive a call from a BCBSIL Personal Health Clinician — experienced registered nurses, pharmacists, dietitians and professionals trained in psychology and social work. We encourage you to take the call or contact a BCBSIL Care Manager at **1-877-239-7449**.

Here are some of the resources you can find when you log in to Blue Access for Members:

My Health

Looking for information on the flu or have a question about how to treat a headache? Find information and advice for all health-related topics including arthritis, cholesterol, diabetes and more.

My Coverage

The Company Medical Plan provides an internet-based self-serice cost transparency/price comparison tool to help you understand costs and coverage for different types of services and care items. The tool:

- Shows you personalized out-of-pocket costs for covered health care items and services (with paper copies available by calling BCBSIL's member services)
- Gives you an estimate of your cost-sharing liability for any In-network provider, so you can compare costs before receiving medical care
- Lets you search by descriptive terms, In-Network Provider name and other relevant factors (such as geography)
- Tracks your progress in meeting any deductibles and Out-of-Pocket Maximums as well as any cumulative treatment limitations (like day or visit limits)

Costs displayed in the tool are estimates for the service or procedure selected and are not a guarantee of charges or payments, but can give you a good idea of what you might owe. Your costs may vary depending on the services performed as part of undergoing treatment. Always confirm that the facility you choose is In-Network and that the procedure is covered under the Plan.

To access BCBSIL's self-service tool, use the self-service cost compare, Cost Estimates, at **bcbsil.com**. To access Cost Estimates, log into your Blue Access for Members account and go to the "Find Care" tab. From there, go to the "Find a Doctor or Hospital" tile and then click on "Cost Estimates." You will see a box that allows you to choose from four different search categories. If you need the information by phone, call **1-877-239-7449**.

Health Plan Decision Tools

Use this tab in the Members section to find tools to help you make health plan and Provider decisions.

Health Plan Cost Estimator

Complete a health profile to obtain your estimated annual health costs. Since you have a choice of Company health plans, use this tool to help you decide which option may be better for you.

Blue365 Discount Program

Blue365 offers you discounts on a range of health-related services and products not covered under the Plan, such as eMindful live streaming or recorded premium courses, weight loss programs and support, Fitbit®, Reebok, SKECHERS® and more. Visit **blue365deals.com/BCBSIL** and register to receive a weekly "Featured Deals" email. You must log in to redeem your offers.

24/7 Nurseline

If you have a health concern and aren't sure if you should go to the emergency room, call your Physician or treat the problem yourself, call the 24/7 Nurseline. Registered nurses can provide guidance on emergency care, urgent care, family care and more — all at no cost to you. Contact the Nurseline at **1-800-299-0274**, 24 hours a day, seven days a week.

Blue Distinction/Blue Distinction+ Centers

You and your covered dependents can use Blue Distinction or Blue Distinction+ Centers for certain high-cost, complex, rare and elective procedures across seven specialties: maternity, transplants, bariatric surgery, cardiac care, knee and hip replacements and spine surgery. When you use one of the centers for a covered procedure, the Plan will reimburse 100% of the cost after you meet your Deductible.

Blue Distinction Centers are recognized for their expertise in delivering specialty care, and Blue Distinction+ Centers are recognized for both their expertise and efficiency. These centers value quality of care above all else — only facilities that meet high national, objective standards are granted Blue Distinction status, and Blue Distinction Centers have a track record for delivering better results than facilities without this distinction. For more information, call the number on your ID card.

Facing a Complex Medical Issue or Surgery? Medical Ally Can Help.
Medical Ally provides clinical information and support so you or a covered dependent can make decisions with confidence regarding routine or complex medical care. The Medical Ally team of nurses, physicians and other health care professionals can help you find:

- The right diagnosis
- Treatment options that are best for your needs
- Doctors who are top-rated for your condition
- The most qualified hospitals for your care
- Support to help you manage your situation

Plus, you have access to Medical Ally's Surgery Decision Support (SDS) program. If you are considering surgery, SDS can help you weigh the risks, benefits and alternative treatment options that could work best for you. Plus, if you participate in the SDS program, you will receive a $400 prepaid card, whether you receive surgery or not!

Call **1-888-361-3944**, go to **mymedicalally.alight.com** or download the **MyMedicalAlly** app (use company code "Bimbo" to register for the first time).

Prescription Drug Benefits

The pharmacy benefit, managed by Express Scripts, is part of the Plan and Prescription Drugs are covered like any other covered medical expense. You can use your HSA funds to pay for your out-of-pocket prescription expenses at an In-Network pharmacy. However, you must pay your share of the Deductible and/or Coinsurance, if your HSA is exhausted or you visit an out-of-network pharmacy. The amount you pay is then applied to your Plan year Deductible.

Note: Once you begin sharing the cost of your prescriptions by paying Coinsurance, there is a limit to the amount you pay out-of-pocket for each prescription.

- The maximum amount you pay for each covered Generic and preferred Brand-Name prescription is $125 at a retail pharmacy or $250 through mail-order, unless you have maintenance medications filled at a retail pharmacy or you choose a Brand-Name Drug when a Generic is available.
- There is no maximum if you choose non-preferred Brand-Name prescriptions. See *How to Fill Prescriptions* on **page 28** and *Generic, Preferred and Non-preferred Drugs* on **page 28** for more information on your costs in those situations.

Manufacturer assistance programs (coupons and discount programs) will not apply toward meeting your annual Deductible and Out-of-Pocket Maximum. Contact Express Scripts member services at **1-866-544-2941** for more information.

	Standard HSA	Enhanced HSA
	After the Plan Deductible, you pay* ...	
Retail (30-day supply)		
Generic and Preferred Brand-Name**	30% after Deductible, $125 max	20% after Deductible, $125 max
Non-preferred Brand-Name	50% after Deductible	40% after Deductible
Mail-Order (90-day supply) – required after the initial fill and two refills***		
Generic and Preferred Brand-Name**	30% after Deductible, $250 max	20% after Deductible, $250 max
Non-preferred Brand-Name	50% after Deductible	40% after Deductible

** Preventive Care medications are not subject to the Plan's Deductible and are immediately covered after you pay the applicable Coinsurance. Medications deemed as "preventive" per the Affordable Care Act (ACA) guidelines are covered at 100% under the prescription benefit.*

*** If you choose to purchase a Brand-Name Drug when a Generic equivalent is available, you will pay 20% or 30% of the Generic prescription cost and 100% of the difference in discounted costs between the Brand-Name and Generic prescription. Your cost will not be applied toward your Deductible or Out-of-Pocket Maximum.*

**** After the initial fill and two refills, you pay 100% of the total cost of the drug if you do not fill your prescription through mail-order or directly at a Walgreens retail pharmacy. Your cost will not be applied toward your Deductible or Out-of-Pocket Maximum. See **page 28** for information on filling a 90-day prescription through mail-order or at a Walgreens retail pharmacy.*

Prior Authorization Required for Certain Prescriptions

For some Prescription Drugs, you must obtain pre-authorization through the coverage review process in order to obtain coverage. A coverage review is performed to determine whether your use of the drug qualifies for coverage. You, your doctor or your pharmacist may request a coverage review by calling Express Scripts at **1-800-753-2851**. **Note:** The telephone number for coverage review is different from the Express Scripts member service telephone number you use for other questions.

Generic, Preferred and Non-preferred Drugs

You must use Generic Prescription Drugs unless no Generic equivalent is available. If a Generic is available and you choose the Brand-Name Drug (preferred or non-preferred), you must pay the difference in cost at the pharmacy (in addition to any Coinsurance that may apply). Additionally, the $125 retail maximum and $250 mail-order maximum Coinsurance cost does not apply. Even if a Physician writes a Dispense as Written (DAW) prescription for a Brand-Name Drug, you still pay the difference.

The difference between the cost of Generic and Brand-Name Drugs does not count toward your Deductible or annual Out-of-Pocket Maximum. **Your HSA can be used to pay the difference between the cost of Generic and Brand-Name Drugs.**

You may use the Express Scripts mobile app to access personalized medical information and the Express Scripts website. In addition, the Express Scripts mobile app can be used to:

- refill and renew mail-order prescriptions
- track the status of mail-order prescription orders
- request mail-order delivery for medications that are currently obtained from a retail pharmacy
- find an In-Network pharmacy near you
- compare drug prices for mail-order and local retail pharmacies
- review Prescription Drug activity and payment details
- access your member ID card

Formulary Drugs

Formulary is a list of covered drugs. Express Scripts' Physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics Committee. This independent body, consisting of Physicians and a pharmacist located throughout the U.S., reviews and approves our formularies.

How to Fill Prescriptions

To receive Plan benefits for your prescription medications, you must fill your immediate or short-term medications at an In-Network retail pharmacy and your on-going or long-term medications through the Express Scripts Home Delivery Pharmacy (the mail-order pharmacy) or directly at a Walgreens retail pharmacy.

Short-Term Medications

Use a retail pharmacy for immediate drug needs or for short-term medications. Fill your original prescription, up to a 30-day supply, by presenting your BCBSIL/Express Scripts ID card at one of 60,000+ In-Network retail pharmacies. You can view In-Network pharmacies on the Express Scripts mobile app or by logging on to **express-scripts.com**. You may only use a retail pharmacy for the initial fill and up to two refills of a medication.

Long-Term Medications

If you need long-term or ongoing medications (i.e., those used to treat chronic medical conditions like high blood pressure, diabetes or asthma), you must use the mail-order pharmacy or go directly to a Walgreens retail pharmacy after you received your initial fill and two refills at a retail pharmacy.

The mail-order pharmacy is convenient and cost-effective, and your medication is delivered to your home. You may also choose to purchase your long-term medication at a Walgreens retail pharmacy for the same cost share as using the mail-order pharmacy. Ask your Physician to prescribe up to a 90-day supply for home delivery or Walgreens retail pharmacy pick-up, plus additional refills as needed (up to a one-year supply of medication).

Note: If you choose not to use the mail-order pharmacy or Walgreens retail pharmacies to get your maintenance medications, the Plan will not cover your prescription and the cost will not apply toward your Deductible or Out-of-Pocket Maximum. You may get up to three fills of your maintenance medication at a retail pharmacy before the policy applies.

Due to government regulations, certain maintenance medications are classified as controlled substances and can only be issued as a 30-day supply by a retail pharmacy or mail-order pharmacy. Therefore, it is not mandatory to use the mail-order pharmacy for these medications. For more information, go to **express-scripts.com**.

Using the Mail-Order Pharmacy

To fill a mail-order prescription, you should:

- mail your prescription(s) to the Express Scripts home delivery pharmacy service, along with an Express Scripts Home Delivery Pharmacy Order Form; or
- ask your Physician to fax your prescription with your BCBSIL/Express Scripts ID card to **1-800-837-0959** (call **1-888-327-9791** for instructions on how to fax a prescription); or
- order through Express Scripts' site after registering on the Express Scripts mobile app or **express-scripts.com**

Orders are usually processed and mailed within 48 hours of receipt. However, you should allow 7 – 11 days for normal mail delivery. To check on the status of your order, visit **express-scripts.com** and click *Order Status*. You can also check the status of your order on the Express Scripts mobile app or call Member Services at **1-866-544-2941**.

Refills through Mail-Order Pharmacy

You can refill a mail-order prescription:

- **Online:** Available prescription refills are displayed in your personalized "order center" when you log on to **express-scripts.com** as a registered user. From the order center, check the box next to the items you want to refill and follow the on-screen instructions
- **By Telephone:** Call **1-866-544-2941** to use the automated refill system
- **By Mail:** Use the refill form that comes with your prescription. Mail it to Express Scripts in the return envelope

To avoid running out of your medication, remember to reorder 14 days before your prescription runs out. You can find the refill date on your prescription bottle, on the refill slip that comes with each order, on your account through the Express Scripts mobile app or **express-scripts.com**. Refills are usually mailed the same day they are ordered.

Using Walgreens for Long-Term Medications

To fill a long-term medication through a Walgreens retail pharmacy, ask your doctor for a new 90-day prescription after you have received your initial fill and two refills. You can order a refill of your long-term medications at your Walgreens retail pharmacy.

Tobacco Cessation Drugs

Tobacco cessation drugs, such as Chantix, Wellbutrin and Zyban, are covered at 100%.

Self-Injectable Medications

Certain self-injectable medications are covered under the Plan. Whether you purchase your medication at a retail pharmacy or through the mail-order pharmacy, you continue to pay based on the Coinsurance schedule. Insulin is covered as any other medication under the Plan and is not subject to these rules.

Paying for Prescriptions

Under the Plan, once your HSA is exhausted you pay for your prescriptions at the time you have them filled. (See *How to Fill Prescriptions* on **page 28** for more information on filling retail and mail-order prescriptions.) Keep in mind that:

- If you choose a Brand-Name Drug when a Generic is available, you are responsible for paying the difference in cost. In addition, the $125 retail maximum and $250 mail-order maximum Coinsurance does not apply, and these additional costs do not count toward your Deductible or your annual Out-of-Pocket Maximum
- If you request a medication that's not covered by the Plan, you must pay the full cost of that prescription. (In some cases, these charges may be eligible for reimbursement through a Health Care Flexible Spending Account, if you have one. **Note:** If you are eligible for an HSA, you are not eligible to enroll in, and contribute to, a general purpose Health Care Flexible Spending Account.)
- Additionally, after you receive the initial fill and two refills of your medications, you must get a new long-term prescription from your doctor and fill your prescriptions through the mail-order pharmacy or directly at a Walgreens retail pharmacy. Otherwise, you pay the full cost of those prescriptions, starting with the fourth refill of maintenance medications at a retail pharmacy. The Plan will not cover your prescription and those costs will not apply toward your Deductible or Out-of-Pocket Maximum

What's Covered

In general, covered items are medications that require a Physician's prescription, are Medically Necessary and are obtained for Outpatient use. To be covered by the Plan, certain medications require prior authorization for medical necessity. For more information about covered drugs and supplies, contact Express Scripts member services at **1-866-544-2941**.

Save Money on Medications

Rx Savings Solutions (RxSS) can help you and your dependents enrolled in a Company medical plan save on prescription drugs. Once registered, you will have access to a website and/or mobile app that alerts you of lower cost options for prescription drugs. For more information about saving money on prescription drugs, call RxSS at **1-800-268-4476**.

What's Not Covered

- anti-wrinkle medications
- blood and blood plasma
- cosmetic therapies
- Durable Medical Equipment such as crutches or wheelchairs
- growth hormones except for the following conditions:
  - adults with hypophyseal dysfunction resulting in symptomatic growth hormone deficiency
  - pediatric human growth hormone deficiency
  - gonadal dysgenesis (Turner syndrome)
  - growth failure secondary to chronic renal failure/ insufficiency in children who have not received a renal transplant
  - Prader Willi syndrome
  - adult growth hormone deficiency syndrome
  - AIDS related cachexia (Serostim only)
  - Small for Gestational Age (SGA) for children over two years old
- hair growth and hair removal treatments
- immunizations, vaccines, allergy agents for injection
- medical devices or equipment
- non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria)
- non-self administered injectable medications (except for insulin and Depo Provera)
- prescriptions exceeding a reasonable quantity as designated by the Plan (i.e., Imitrex tablets, 18 per month)
- products used at or dispensed at an Outpatient or Inpatient facility, clinic, or Physician's office, including Hospitals, extended/nursing care homes, home care service, home infusion services
- products not approved for use in the United States, or used for Experimental therapy
- products purchased outside the United States unless in an emergency situation
- therapy for anyone other than the recipient of prescription, as eligibility permits
- weight loss medications

How the Plan Administrator Can Use Prescription Drug Plan Information

Under the Employee Retirement Income Security Act of 1974 (ERISA), prescription records for you or your dependents may be disclosed to the Company in its capacity as Plan Administrator (the one responsible for the Plan). This information will be used only to decide claims under the Plan. Prescription Drug records for you and your dependents will remain confidential.

In addition, if the Company is informed that you or one of your dependents is misusing Prescription Drug coverage, the Plan Administrator can use this information to deny benefits under the terms of the Plan. If this misuse violates a state or federal law, the Plan Administrator will release information to the proper legal authorities in compliance with applicable law. Prescription Drug records for you and your dependents will remain confidential for all other purposes.

For a description of your rights under ERISA, see ERISA Rights in the Company Plan Administrative SPD.

Specialty Pharmacy Services
Specialty pharmacy services are available through Accredo for those with certain complex and chronic health conditions. Accredo's team of pharmacists, nurses, patient care advocates, social workers and insurance coordinators are available to answer questions about your medications and side effects, provide in-home training and reach out on a regular basis to monitor therapy adherence. For more information, contact Accredo at **1-800-803-2523**.

Medicare Part D Prescription Drug Coverage

If you enroll in a Medicare Part D Prescription Drug Plan ("Medicare PDP") and drop your Company Prescription Drug coverage, assuming it is offered, you may be paying additional premiums for coverage you already have under the Company Medical Plan. You should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription Drug coverage in your area. It is important for you to consider your options very carefully. Keep in mind that:

- Medicare Prescription Drug coverage is available to everyone with Medicare through a Medicare PDP. All Medicare PDPs provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. The Company has determined that the Prescription Drug coverage under this Plan is, on average for all participants, expected to pay as much or more than the standard Medicare Prescription Drug benefit in 2024. This is known as "creditable coverage."
- If you or your covered dependent(s) are enrolled in Company prescription drug coverage during 2024 and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. Individuals can enroll in a Medicare PDP when they first become eligible for Medicare and each year from October 15th through December 7th. If you and other eligible beneficiaries leave your Company coverage, you also may be eligible for a special enrollment period to sign up for a Medicare PDP. **If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice does not apply to you**.
- If you are an active associate or family member of an active associate and you drop your Company Prescription Drug coverage and enroll in a Medicare PDP, Medicare may be your only payor. You can re-enroll in the Company Prescription Drug coverage at Annual Enrollment or if you have a special enrollment event for the Company Prescription Drug Plan, assuming you remain eligible. If you decide to enroll in a Medicare PDP and you are an active associate or family member of an active associate, you may also continue your employer coverage. In this case, the Company Prescription Drug coverage will continue to pay primary or secondary as it had before you enrolled in Medicare PDP. You should also know that if you drop or lose your coverage with the Company and don't enroll in Medicare Prescription Drug coverage after your current coverage ends, you may pay more to enroll in Medicare Prescription Drug coverage later. If you go 63 days or longer without Prescription Drug coverage that is at least as good as Medicare's Prescription Drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next October to enroll.

Before making your final decision about Prescription Drug coverage, it is important that you consider this information as well as the coverage provided through Medicare and this Plan. For more information, you can contact the BBU Benefits Center at **1-888-60-myBBU** (1-888-606-9228).

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit **medicare.gov** for personalized help
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available from the Social Security Administration (SSA). Visit SSA at **socialsecurity.gov** or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Keep this SPD
If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For additional information on Medicare, please contact HTA at **1-610-430-6650, Option 1** to schedule a Medicare consultation or visit **hta-insurance.com**.

Wellness Screening

You can earn up to $900 per year in discounts toward your Plan premiums (the amount taken from your paycheck to pay for your Company medical coverage) for getting a Wellness Screening and achieving healthy results. If your spouse is enrolled in the Company Medical Plan, he/she can also earn up to $900 per year in Plan premium discounts. Participation in the Wellness Screening is voluntary. There is no cost to you and your enrolled spouse to participate; the cost of the Wellness Screening is paid by the Company.

The voluntary wellness program is available to all associates. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate 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 (HIPAA), as applicable, among others.

Salaried and non-union hourly associates and enrolled spouses will be asked to complete a biometric screening, which will include a blood test for cotinine to test for tobacco use. You must complete a biometric screening to be eligible to receive any discounts, or you need to complete and submit an appeals form (signed by a doctor) certifying that your participation in a biometric screening is not medically appropriate. Results from your biometric screening (if applicable) will be used to provide you with information to help you understand your current health and potential risks. You are encouraged to share your results or concerns with your doctor.

Salaried and non-union hourly associates and enrolled spouses will receive an incentive (medical plan premium discounts) for:

- Completing the biometric screening ($180 discount, per year/per person)
- Being tobacco-free ($360 discount, per year/per person)
- Demonstrating a BMI under 30 or a waist circumference of 35" or less for women, or 40" or less for men ($360 discount, per year/per person)

Your total annual discount could be as much as $900, or $1,800 if your enrolled spouse participates, too.

Although you are not required to complete the biometric screening, only associates and enrolled spouses who do so will receive medical plan premium discounts.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn the incentive, you may be entitled to a reasonable accommodation or an alternative standard. Please check the Quest portal to access the *Physician Waiver Form*. You will need to have the form completed by your physician and submit it to Quest for processing by the deadline.

If you/your enrolled spouse are not tobacco-free, the Pelago Tobacco Cessation Program is the reasonable alternative standard to allow you to earn the incentive. You can learn more about the Program and how to enroll by calling **1-877-349-7755** or visiting **my.pelagohealth.com/client/expressscripts**. Once you/your enrolled spouse have enrolled and completed the Pelago Tobacco Cessation Program, you will earn the "being tobacco-free" incentive.

If you/your enrolled spouse do not receive the healthy BMI medical plan premium discount, you may be eligible to receive the discount as a retroactive reimbursement if you/your enrolled spouse achieve the BMI/waist circumference guideline or reduce your weight by 5% when you test during the next Wellness Screening testing period.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Company may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach involving information you provide in connection with the wellness program occurs, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Right to Privacy

Quest Diagnostics results, Pelago Tobacco Cessation Program and other third-party vendor resources available through the wellness program are completely confidential. These wellness program partners only share aggregate, de-identified health data with the Company or the Plan. To administer Premium discounts for eligible individuals, information will be passed on to the payroll contacts, but confidentiality is maintained. See HIPAA Privacy Rights in the Company Plan Administrative SPD.

How to Participate and Earn Discounts

During each Annual Enrollment testing period, you and your spouse have an opportunity to participate in the program and earn Plan premium discounts by taking healthy actions and achieving healthy results.

Healthy Action or Result	Details	You and your spouse can each earn discounts of...
Healthy Action: Get Your Wellness Screening	You and your spouse can get a free Wellness Screening to measure Body Mass Index (weight, height and waist circumference), blood pressure, cholesterol, A1c, creatinine and blood glucose levels (blood test) and tobacco use (blood test). You can get your screening at an on-site screening event, Quest Diagnostics Patient Service Center (PSC), or from your personal Physician To get a screening from your Physician, visit **my.questforhealth.com** to download and print the *Physician Results Form* and the instructional form that accompanies it. Take this form to your personal Physician to complete during a visit and return the form to Quest Diagnostics via fax at **1-844-560-5221** or upload to **my.questforhealth.com**. By submitting this form, you are requesting that your Physician release the private health information from your preventive screening results to Quest Diagnostics to be included as part of the Company wellness program	$180 per year/per person in Plan premium discounts for getting a Wellness Screening
Healthy Result: Be Tobacco-Free	The Wellness Screening will show if you use any types of tobacco — cigarettes, cigar, chewing tobacco, vaping, etc.	$360 per year/per person in Plan premium discounts for being tobacco-free
Healthy Result: Have a BMI Under 30 or a Healthy Waist Circumference (35" or less for women, or 40" or less for men)	The Wellness Screening will show if you have a BMI under 30 or a waist circumference of 35" or less for women, or 40" or less for men	$360 per year/per person in Plan premium discounts for having a BMI under 30 or a healthy waist circumference of 35" or less for women, or 40" or less for men

The maximum amount you can each earn for the 2024 Plan year is $900 per year. You do not need to take all actions or achieve all results to receive any discounts. For example, if you complete the Wellness Screening and you are tobacco-free, but your BMI is above 30 and you do not reach the waist circumference requirements, you will receive two of the three discounts.

When you are first hired, you will receive the full discounts through the end of the current Plan year, unless otherwise noted. When you test during the Annual Enrollment testing period, discounts will begin effective January 1 of the following year. Once your screening has been completed, you will not be permitted to screen again until the next Annual Enrollment testing period.

Pelago

Pelago is a confidential addiction support program to help people quit smoking, cut back on alcohol* or overcome opioid dependence* with the help of scientifically proven techniques and expert coaches and counselors. Once registered, you can receive one-on-one virtual coaching with a personal coach/counselor, 24/7 access to self-guided activities and medications to help reduce cravings for nicotine, alcohol or opioids. To learn more about Pelago, call **1-877-349-7755** or visit **https://my.pelagohealth.com/client/expressscripts**.

**Alcohol and opioid support are not available in all states. Visit the Pelago website or call 1-877-349-7755 to confirm eligibility*

Retesting

If you and/or your spouse show tobacco use and/or have a BMI of 30 or more or a waist circumference of more than 35" for women, or more than 40" for men, you will not receive the applicable Plan premium discount(s). However, you can retest during each Annual Enrollment testing period, established and communicated by the Company each fall. The screening process is the same as that outlined in *Wellness Screening* on **page 32**.

If retest results show you are tobacco-free or you complete the Pelago program in 2024, and/or achieved a BMI under 30 or a waist circumference of 35 inches or less for women, or 40 inches or less for men, or have reduced your weight by 5%, you will receive the applicable Plan premium discount, as a taxable refund, retroactive to your benefits effective date or your last testing date, whichever is later. You will also receive the applicable Plan premium discount for the following calendar year.*

**If you participate in the Pelago program but still test positive for tobacco, or if you lost 5% of your weight but still do not reach the BMI/waist circumference criteria, you will not receive the premium discount for next year.*

Paying for Your Wellness Screening

The Company covers the cost of a Wellness Screening for you and your spouse during an onsite screening event, at a Quest Diagnostics Patient Service Center or from your In-Network Physician at 100% when you are covered by the Company Medical Plan.

- If you have your Physician perform some or all aspects of the screening, ask your Physician to code the visit as a Preventive Care visit, not as a diagnostic visit, to ensure proper processing. The Company Medical Plan does not limit the number of In-Network Preventive Care visits one person can have in a year.
- If you incur any incremental medical charges for the Wellness Screening, including the cotinine test for tobacco use, the Company will reimburse you for the cost when you submit a *Wellness Screening Reimbursement Form*. You can access this form on GB-on, or email **HRBenefitSolutions@grupobimbo.com** to request a form be sent to you.

If you or your spouse gets a screening when you are not covered by the Company Medical Plan (e.g., during a waiting period) or before you enroll in Company medical coverage, you will have to pay for your screening at the time of service, and then submit a *Wellness Screening Reimbursement Form* to be reimbursed for the expense. You must use a Physician who accepts BCBSIL in-network insurance for the Company to reimburse the cost of your visit. You can access this form on GB-on, under the "Health and Wellness" section of the "Tools and Resources" tab, or email **HRBenefitSolutions@grupobimbo.com** to request a form be sent to you.

- To submit your request for reimbursement, you must submit the *Wellness Screening Reimbursement Form* and the receipts for your medical services to the Company by the Annual Enrollment testing period deadline established each year. To be eligible for reimbursement, you must have your Physician also submit a *Physician Results Form* or *Wellness Screening Reimbursement Form* on your behalf. The reimbursement request can be submitted to the Benefits Department by emailing the form to **HRBenefitSolutions@grupobimbo.com** or by mailing to form to the Benefits Department, 355 Business Center Drive, Horsham, PA 19044. By signing the form, you approve the release of your participation information to Quest Diagnostics to verify your eligibility for reimbursement.
- If you do not complete the reimbursement process by the Annual Enrollment testing period deadline established each year, the Company will not be able to process your cost reimbursement. Also, only medical expenses related to the screening will be reimbursed. The Company will not reimburse for incidental expenses such as transportation costs or any separate fees the Physician may charge for filling out either the *Physician Results Form* or *Wellness Screening Reimbursement Form*. Please remember that requests for reimbursement must be submitted by the Annual Enrollment testing period deadline established each year, in order to qualify for reimbursement. Requests submitted after that date will not be accepted.
- Your approved expense reimbursement will be paid to you approximately eight weeks after the submission deadline. Please note that the reimbursement will be paid the same way you receive your paycheck. If you receive a paper check, the reimbursement will be sent to you as a paper check. If you have signed up for direct deposit, your reimbursement payment will be direct deposited into your account on file.

Wellness Screening Appeals

Contact HR Benefit Solutions at **HRBenefitSolutions@grupobimbo.com**.

Wellness Screening Exceptions, Waivers and Reasonable Alternatives

Certain medical conditions or health situations (e.g., thyroid issues or pregnancy) could make it unreasonably difficult or inadvisable to participate in a venipunture blood test or meet healthy results. In some cases, a Physician might certify that a program standard, when applied to a particular individual, is an inaccurate or inappropriate measure of health and should be waived. In such a case, the Company will consider providing an individual with a waiver for the wellness program requirements. The Company also will waive program requirements whenever necessary to comply with federal, state or local law. Note that individuals on nicotine replacement therapy do not qualify for a waiver while on their nicotine replacement therapy.

Wellness Screening

If your Physician confirms it is not medically appropriate for you or your spouse to obtain a venipuncture blood test, the Company will waive the blood test requirement to earn the Wellness Screening discount.

Tobacco

If your Wellness Screening results show you or your spouse are not tobacco-free, you can earn the tobacco-free Plan premium discount by completing the Pelago Tobacco Cessation Program at **1-877-349-7755** or **my.pelagohealth.com/client/expressscripts**. You will receive a taxable refund if you complete this program. You must test negative for tobacco to receive the medical plan premium discount for the following calendar year.

If retest results show you are tobacco-free, you will receive the applicable Plan premium discount retroactive to your benefits effective date or your last testing date, whichever is later, as a taxable lump-sum payment. You will also receive the applicable Plan premium discount for the following calendar year.

Weight

If your results show you or your spouse do not achieve healthy results (BMI under 30 or a waist circumference of 35" or less for women, or 40" or less for men), you can earn the discount by achieving healthy results at the next Annual Enrollment testing period.

If retest results show you have achieved a BMI under 30 or a waist circumference of 35" or less for women, or 40" or less for men, or have reduced your weight by 5%, you will receive the applicable Plan premium discount as a taxable refund retroactive to your benefits effective date or your last testing date, whichever is later. You will also receive the applicable Plan premium discount as a taxable refund for the following calendar year.

If at the time of the next Wellness Screening, you reduce your weight by 5% or your Physician determines that the Company's healthy results standard for weight is not medically appropriate for you, you can obtain a second alternative weight standard, which is compliant with the recommendations of your personal Physician regarding weight, diet and exercise as set forth in a treatment plan that your Physician recommends or to which your Physician agrees. You will receive the applicable Plan premium discount as a taxable lump-sum refund for the current year.

To receive a waiver or a healthy results reasonable alternative as recommended by your Physician, you must have a Physician complete and submit a *Healthy Standard Appeals Form*, available on GB-on, or have the form sent to you by emailing **HRBenefitSolutions@grupobimbo.com**.

To submit your request for a waiver, your Physician must complete and submit the *Healthy Standard Appeals Form*. If you are retesting, or resubmitting a waiver form, the form must be submitted by the deadline established each year for the Annual Enrollment testing period.

The waiver form can be submitted by email to **HRBenefitSolutions@grupobimbo.com** or by mail to the Benefits Department, 355 Business Center Drive, Horsham, PA 19044. By signing the form, you authorize your Physician to release the private health information contained in the form to the Company.

Applicable Plan premium discounts will apply as soon as administratively possible after a completed waiver form is received. You will receive discounts only for those criteria that your Physician has indicated should be waived. For any remaining criteria, you will not earn discounts unless you participate in the program as outlined in *How to Participate and Earn Discounts* on **page 34**.

Critical Illness Insurance

Critical Illness Insurance provides financial protection if you or a covered dependent is diagnosed with a critical illness (see *Covered Conditions* below). This benefit helps cover Deductibles, medical insurance Coinsurance, home health care needs, rehabilitation, child care expenses and more. Coverage is provided through Securian.

Critical Illness Insurance is intended to supplement your Company Medical Plan coverage and does not provide the minimum level of medical coverage needed to meet the Affordable Care Act requirement for medical insurance. Critical Illness Insurance benefits and provisions available in your state may differ from those described here. You are eligible for:

- **Basic Critical Illness:** The Company provides all associates who are enrolled in either the Standard HSA or Enhanced HSA medical plan with $3,000 company-paid Basic Critical Illness coverage.
- **Voluntary Critical Illness:** You can enroll in Voluntary Critical Illness coverage, offered through Securian, and select either $10,000 or $20,000 of insurance for yourself only or yourself and eligible dependents.

How Critical Illness Insurance Works

A lump-sum payment is paid directly to you and can be used to help offset out-of-pocket medical expenses (Deductible, Coinsurance, etc.), or other expenses (lost income, household bills, etc.) arising from the critical illness. Critical Illness Insurance pays in addition to your Company Medical Plan and benefits are payable regardless of any other insurance programs.

Covered Conditions

Critical Illness Insurance provides benefits for the following conditions:

- heart attack
- cancer
- stroke
- major organ failure
- kidney failure
- coronary artery disease needing surgery or angioplasty

Multiple Payout and Recurrence

If you file a claim and receive benefits for a covered condition and then experience a second condition with a different diagnosis separated by more than 30 days, you receive a benefit payment for the second separate condition.

If you receive benefits for a covered condition and then experience a recurrence of the same covered condition, you receive a benefit equal to 50% of the covered amount for the recurrence, if the recurrence occurs 12 months after the first occurrences of the covered condition.

Exclusions and Limitations

The following exclusions and limitations apply to critical illness coverage.

General Exclusions and Limitations

Benefits for covered conditions will be payable upon a diagnosis of a covered condition that satisfies the requirements of the policy and when all other policy requirements are met. Benefits are never payable for a covered condition that is caused directly or indirectly by, results in whole or in part from, or for which there is contribution from any of the following:

- self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane
- suicide or attempted suicide, whether sane or insane
- your commission of, or attempt to commit, a felony or to which a contributing cause was your being engaged in an illegal occupation
- the use of alcohol, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected
- motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto
- war or any act of war, whether declared or undeclared
- your service in the armed forces or units auxiliary to it of any nation

Critical Illness Insurance Claim Example

You enroll in voluntary critical illness insurance. After your coverage is effective, you have a heart attack. The payment example below highlights the cash payment you would receive as a result of a heart attack.*

Associate voluntary critical illness election: $20,000	Benefit
Heart Attack	$20,000
Securian Financial pays you:	$20,000

If enrolled in basic critical illness insurance, you would receive an additional $3,000 benefit.

**Actual experience and benefit payouts may vary from this example.*

Additional Limitations

Full Benefit Cancer

The following cancers are not considered full benefit cancer and are excluded:

- all tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades), or intraepithelial neoplasia
- any lesion described as Ta or as carcinoma in-situ (Tis) by the AJCC Staging System
- all non-melanoma skin cancers unless there are lymph node or distant metastases
- prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to six, without lymph node or distant metastasis
- any melanoma that is less than or equal to 1.0 mm in Breslow thickness, without lymph node or distant metastasis
- early thyroid cancer that is classified at T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis

Heart Attack

Angina and all other forms of acute coronary syndromes are not covered. The diagnosis must be made by a specialist, supported by all three of the following criteria and be diagnostic of a new acute myocardial infarction:

- symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infraction,
- new characteristic electrocardiographic changes, and
- the characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins

Stroke

The diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new stroke. The following are excluded:

- transient ischemic attacks (TIA) or reversible ischemic neurologic deficit (RIND)
- brain damage due to an accident or injury
- disorders of the blood vessels affecting the eye including infarction of the optic nerve or retina
- ischemic disorder of the peripheral vestibular system
- asymptomatic silent stroke found on imaging

Major Organ Failure

A specialist must state that the insured needs a transplant of the mentioned organs and the insured is included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). The transplant must be deemed necessary by a specialist to treat organ failure in the insured. If an insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid. The following are not covered:

- transplant of any other organs, tissues or cells
- registration on an official USA transplant waiting list as a donor

Kidney Failure

Permanent regular renal dialysis or kidney transplant must be deemed Medically Necessary by a specialist. Acute reversible kidney failure that only needs temporary renal dialysis is not covered.

Partial Benefit Cancer

The following cancers are excluded:

- all tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia
- non-melanoma skin cancer
- carcinoma in-situ of the skin
- melanoma in-situ

Coronary Artery Disease Needing Surgery or Angioplasty

A specialist must report that the insured required surgical intervention on the coronary artery(s) following clinically accepted cardiovascular surgery guidelines, either for prognostic benefit or for symptomatic coronary artery disease that cannot be adequately managed on optima medical therapy. Diagnostic coronary angiography is not considered a 'surgical intervention' under this definition and it is specifically excluded.

Accident Insurance

Accident Insurance provides a cash benefit to help cover out-of-pocket expenses after suffering a covered accident. You and/or your covered family members could receive a lump-sum benefit for a variety of accidental injuries that occur off the job (e.g., fractures, dislocations, concussions).

You may purchase voluntary Accident Insurance coverage through Securian if you are eligible for coverage under the Company Medical Plan. You may choose between a low and high plan, and may enroll yourself only or yourself and eligible dependents.

How Voluntary Accident Insurance Works

A lump-sum payment is paid directly to you and can be used to pay for medical services and treatments (e.g., doctor visits, ambulance transportation, medical testing and physical therapy) or daily living expenses like rent and groceries; it's your choice.

The amount paid to you should you have an accident will depend on your choice of low or high plan, the number of benefits you qualify for, the care you received as a result of your accident and the term and conditions of the policy.

Voluntary Accident Insurance Claim Example

You enroll in voluntary accident insurance — high plan. Ten months later, you fall off a ladder. The cash benefits from your injury can be used to help with medical costs such as copays, deductibles or costs you may not think of such as groceries or child care.*

Associate voluntary accident insurance	Benefit
Laceration with stitches	$500
Emergency room treatment	$200
Ambulance (ground)	$300
Securian Financial pays you:	$1,000

**Actual experience and benefit payouts may vary from this example.*

Covered Conditions

This is an outline of the covered benefits available through the low and high plans. The amount paid to you should you have an accident will depend on your choice of low or high plan, the number of benefits you qualify for, the care you received as a result of your accident and the term and conditions of the policy.

Covered Benefits	Low Plan or High Plan	
Cash benefits paid per accident.		
Burns (2nd degree) Varies based on percent of body burned	Up to $500	Up to $1,500
Burns (3rd degree) Varies based on percent of body burned	Up to $5,000	Up to $15,000
Skin graft	50% of burn benefit	50% of burn benefit
Child organized sports injury Live birth to age 18	$100	$200
Concussion	$100	$200
Dislocation (surgical)		
Hip/Thigh	$3,000	$6,000
Knee	$2,250	$4,500
Foot	$1,200	$2,400
Ankle	$1,200	$2,400
Hand	$600	$1,200
Wrist	$900	$1,800
Lower jaw	$600	$1,200
Shoulder	$900	$1,800
Collarbone	$600	$1,200
Ribs	$600	$1,200
Elbow	$600	$1,200
Finger	$300	$600
Toe	$300	$600
Non-surgical	50% of surgical benefit	50% of surgical benefit
Partial dislocation	25% of non-surgical benefit	25% of non-surgical benefit
Eye injury		
With surgery	$150	$300
Removal of foreign object	$50	$100

Covered Benefits	Low Plan or High Plan	
Fracture (surgical)		
Skull – depressed	$4,500	$9,000
Hip/Thigh	$3,000	$6,000
Skull – non-depressed	$3,000	$6,000
Pelvis	$2,250	$4,500
Sternum	$2,250	$4,500
Vertebral body	$1,500	$3,000
Lower leg	$1,500	$3,000
Shoulder blade	$1,500	$3,000
Upper arm	$1,050	$2,100
Facial excluding lower jaw	$1,050	$2,100
Foot	$750	$1,500
Ankle	$750	$1,500
Kneecap	$750	$1,500
Forearm	$750	$1,500
Hand or wrist (except fingers)	$900	$1,800
Lower jaw	$750	$1,500
Ribs	$750	$1,500
Vertebral processes	$600	$1,200
Collarbone	$450	$900
Coccyx	$300	$600
Finger	$300	$600
Toe	$300	$600
Nose	$300	$600
Non-surgical	50% of surgical benefit	50% of surgical benefit
Chip fracture	25% of non-surgical benefit	25% of non-surgical benefit
Lacerations		
With stitches or staples	$200	$500
Without stiches or staples	$50	$125

Emergency Care	Low Plan or High Plan	
Ambulance		
Ground or water	$150	$300
Air	$500	$1,000
Blood, plasma or platelets transfusion	$300	$600
Emergency dental		
Crown	$150	$300
Extraction	$50	$100
Emergency room treatment	$100	$200
Initial physician's office visit	$50	$100

Hospital Care	Low Plan or High Plan	
X-Ray	$25	$50
Diagnostic testing	$100	$200
Hospital stay – initial benefit		
Non-ICU	$1,000	$2,000
ICU	$1,000	$2,000
Hospital stay – daily benefit		
Non-ICU	$100	$200
ICU	$200	$400
Spinal injection for pain management	$25	$75
Surgical anesthesia	$75	$150

Support Care	Low Plan or High Plan	
Adaptive home and vehicle	$500	$1,000
Appliances	$50	$150

Surgery	Low Plan or High Plan	
Abdominal or pelvic	$1,000	$2,000
Cranial surgery – Inpatient surgery	$1,000	$2,000
Knee cartilage		
Open	$500	$1,000
Arthroscopic	$250	$500
Ruptured disc	$500	$1,000
Tendon, ligament or rotator cuff		
Open	$500	$1,000
Arthroscopic	$250	$500
Thoracic surgery	$1,000	$2,000

Follow-Up Care	Low Plan or High Plan	
Follow-up physician's office visit	$50 (up to 6 visits per accident)	$100 (up to 6 visits per accident)
Prosthetics		
One	$500	$1,000
Two or more	$1,000	$2,000
Rehabilitative therapy		
Inpatient	$100 per day (up to 30 days)	$200 per day (up to 30 days)
Outpatient	$25 per day (up to 6 sessions)	$50 per day (up to 6 sessions)
Transportation	$200 per visit (up to 2 visits per accident)	$400 per visit (up to 2 visits per accident)

Multiple Payout and Recurrence

Some covered benefits include limitations on the number of benefit payments payable per insured person, per covered accident, and per year. For example, some benefits included in the policy have limits on the number of benefits that can be paid on a per-accident or per-year basis, which varies by the covered condition.
Please note there is no limit to the number of accidents that can qualify for a benefit and there is no limit on the number of separate benefits you can qualify for as a result of the same covered accident. In addition, there are no lifetime benefit maximums.

Exclusions and Limitations

The following exclusions and limitations apply to Voluntary Accident Insurance.

General Exclusions and Limitations

In no event will we pay benefits where the insured's accident, injury or loss is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

1. self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane;
2. suicide or attempted suicide, whether sane or insane;
3. an insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
4. bodily or mental infirmity, illness, disease, or infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury;
5. the use of alcohol;
6. the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected;
7. motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto;
8. medical or surgical treatment or diagnostic procedures including any resulting complications, or when the outcome is not as planned or expected, including claims of medical malpractice;
9. travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft;
10. war or any act of war, whether declared or undeclared;
11. participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing;
12. riding or driving in any motor-driven vehicle in a race, stunt show or speed test; or
13. practicing for or participating in any semi-professional or professional competitive athletics.
14. repetitive stress syndromes including but not limited to rotator cuff syndrome, bursitis, tendonitis, carpal tunnel syndrome, ulnar nerve syndrome, stress fractures, neuropathy, epicondylitis or neuritis.

Additional Limitations

Benefits are not payable for any care, treatment or diagnostic measures that were received outside of the United States or a United States territory.

Other benefit limitations may exist and vary by covered benefit. Securian Life cannot provide legal or tax advice with respect to ERISA; Health Savings Account (HSA) laws, rules or regulations, any applicable tax laws, rules or regulation; or any other applicable federal or state laws, rules or regulation. Any questions regarding these topics should be directed to your legal and tax advisors.

Group accident insurance is issued by Securian Life Insurance Company, a New York authorized insurer headquartered in St. Paul, MN.

Product availability and features may vary by state.

This product is offered under policy form series 15-32400.

This policy provides limited benefits. This policy has exclusions, limitations, terms under which the policy may be continued in force or discontinued. This is a summary of plan provisions related to the insurance policy issued by Securian Life. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations and terms of coverage. All elections or increases are subject to the actively at work requirement of the policy.

Hospital Indemnity Insurance

Hospital Indemnity Insurance provides financial protection if you or a covered dependent is hospitalized. This benefit helps cover Deductibles, medical insurance Coinsurance, home health care needs, rehabilitation, childcare expenses and additional out-of-pocket costs. Coverage is provided through Securian.
Hospital Indemnity Insurance is intended to supplement your Company medical plan coverage and does not provide the minimum level of medical coverage needed to meet the Affordable Care Act requirement for medical insurance. Hospital Indemnity Insurance benefits and provisions available in your state may differ from those described here. You are eligible for:

- **Voluntary Hospital Indemnity Insurance:** You can enroll in Voluntary Hospital Indemnity coverage, offered through Securian, and select either the low or high plan for yourself only or yourself and eligible dependents.

How Hospital Indemnity Insurance Works

A lump-sum payment is paid directly to you and can be used to pay for medical bills (e.g., ambulance transportation, medical testing) or daily living expenses like rent and groceries; it's your choice.

The amount paid to you should you be hospitalized will depend on your choice of low or high plan, the number of benefits you qualify for, the care you received as a result of your hospital stay and the term and conditions of the policy.

The charts below summarize the covered benefits available through the low and high plans.

Covered Benefits	Low Plan	High Plan
Hospital stay — initial benefit (sickness or accident)		
Non-ICU	$1,000	$2,000
ICU	$1,000	$2,000
Hospital stay — daily benefit (sickness or accident)		
Non-ICU	$100	$200
ICU	$200	$400
Newborn routine stay (up to 2 days)	$100 per day	$200 per day
Outpatient mental health diagnostic screening (once per year)	$50	$100

Please note that the hospital stay daily benefit and the newborn routine stay benefit are both paid out on the first day. Therefore, if you go into the hospital on June 1, you will be paid for the initial stay benefit as well as the corresponding daily benefits for June 1. Hospital stay daily benefits are limited to 30 non-ICU days and 10 ICU days per confinement.

Exclusions and Limitations

The following exclusions and limitations apply to Hospital Indemnity Insurance.

General Exclusions and Limitations

Benefits are never payable where the insured's accident, injury or sickness is caused from any of the following:

- self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane;
- suicide or attempted suicide, whether sane or insane;
- an insured's commission of, or attempt to commit, a felony, or engagement in any illegal occupation;
- the use of alcohol (this exclusion does not apply to the inpatient substance abuse treatment benefit and the inpatient mental health treatment benefit);
- the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected (this exclusion does not apply to the inpatient substance abuse treatment benefit and the inpatient mental health treatment benefit);
- war or any act of war, whether declared or undeclared;
- dental or plastic surgery for cosmetic purposes except when due to: a) reconstructive surgery, when the service is related to or follows surgery resulting from a covered accident or sickness; or b) a congenital disease or anomaly of a covered dependent child; or c) congenital defects in newborns;
- a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital (this exclusion does not apply to the newborn routine stay benefit).

Additional Limitations

In no event will Securian pay benefits when the insured's accident or injury is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

- motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto;
- bodily or mental infirmity, sickness;
- infection, other than infection occurring simultaneously with, and as a direct and independent result of, the injury;
- travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft;
- participation in the following activities: scuba diving, bungee jumping, base jumping, hang gliding, sail gliding, parasailing, parakiting, or mountain climbing;
- riding or driving in any motor-driven vehicle in a race, stunt show or speed test;
- resulting complications from medical or surgical treatment or diagnostic procedures when the outcome is not as planned or expected, including claims of medical malpractice; or
- practicing for or participating in any semi-professional or professional competitive athletics.

Hospital Indemnity Insurance Claim Example

You enroll in voluntary Hospital Indemnity Insurance — high plan. After your coverage is effective, you break your leg on a ski trip. You don't need surgery, but you spend two days in the hospital. The cash benefits from your hospital stay can be used to help with medical costs such as copays, deductibles or costs you might not think of such as groceries or childcare.*

Associate voluntary hospital indemnity	Benefit
Hospital Stay or Admission — Initial Benefit Non-ICU	**$2,000**
Hospital stay — daily benefit Non-ICU	**$200 per day for your 2-day hospital stay**
Securian Financial pays you:	**$2,400**

**Actual experience and benefit payouts may vary from this example.*

Glossary

Advanced Practice Nurse

A Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of their certification.

Autism Spectrum Disorders

Means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Brand-Name Drugs

Drugs that are under patent and only available from one manufacturer.

Coinsurance

The percentage of eligible medical and pharmacy expenses that Covered Persons are required to pay under the Company Medical Plan.

Congenital or Genetic Disorder

Means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorder may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

Coverage Date

Means the date on which your coverage under the Company Medical Plan begins.

Covered Expenses

Expenses for covered medical and pharmacy services used to calculate a Covered Person's Deductible, Coinsurance, benefits and benefit maximums while the Plan is in effect.

Covered Expenses for In-Network Providers, or for out-of-network Providers as a result of an emergency or other arrangement, are the contracted fees for services negotiated by BCBSIL or Express Scripts.

Covered Expenses for out-of-network Providers are the lesser of:

- Provider's allowable charge;
- Medicare allowable payment;
- lowest amount that would have been paid to an In-Network Provider for the same service; or
- Reasonable and Customary Charge

Covered Expenses must not exceed the fees the Provider would normally charge for the same services to any other similar plan. If an out-of-network Provider routinely waives Coinsurance and/or the annual Deductible for out-of-network benefits, health services for which the Coinsurance and/or annual Deductible are waived are not considered Covered Expenses.

Covered Person

The eligible associate and/or his/her spouse or child, if any, covered under the Plan.

Covered Provider

An individual who:

- provides services covered by the Plan;
- has training that meets all legal requirements;
- is licensed by the state or jurisdiction; and
- is practicing within the scope of his/her license

Qualified Covered Providers include (but are not limited to) chiropractors, dentists, medical Physicians, Physicians of osteopathy, podiatrists, psychologists, licensed counselors providing treatment for mental disorders, acupuncturists (if licensed MDs) and persons with master's degrees in social work.

Covered Services

Service, supplies, equipment, devices or drugs to prevent, diagnose or treat a Sickness, accidental injury or symptom for which benefits will be provided when they are:

- covered by the Plan
- supported by national medical standards of practice
- consistent with conclusions of prevailing medical research that demonstrate the services have a beneficial effect on health outcomes and are based on:
  - well-conducted, randomized controlled trials (comparing two or more where the patient is not allowed to choose the treatment received);
  - well-conducted cohort studies (comparing patients receiving trial treatment to a nearly identical group of patients receiving standard therapy);
  - not Experimental/Investigative or Unproven Services and Supplies; and
  - the most cost-effective method that yields a similar outcome to other available alternatives

Custodial Care

Services and supplies, furnished to a person mainly to help him/her in the activities of daily life, regardless of disability status, that meet one of the following criteria:

- non-health related services, such as assistance in activities of daily living (including, but not limited to, feeding, dressing, bathing, transferring and ambulating);
- health-related services that do not seek to cure or are provided to a patient during periods when the medical condition is not changing; or
- services that do not require continued administration by trained medical personnel

Deductible

The amount of covered medical expenses a Covered Person must incur within a calendar year before any benefits are payable during that year, unless otherwise stated in the summary of benefits. This amount can be paid through the Company-funded HSA, and then through Member Responsibility after the HSA has been exhausted.

Durable Medical Equipment

Medical equipment that:

- serves a medical purpose;
- is not disposable;
- can withstand repeated use;
- is appropriate for home use;
- is generally not useful to a person who is not sick or injured;
- is not available without a prescription;
- is not used to enhance the patient's home environment;
- is not used to alter air quality or temperature; and
- is not for exercise or training

Some examples of Durable Medical Equipment include:

- appliances that replace a lost body organ or part or help an impaired one to work
- orthotic devices such as arm, leg, neck or back braces
- Hospital-type beds
- equipment needed to increase mobility, such as a wheelchair
- respirators or other equipment for the use of oxygen
- monitoring devices

Not included is equipment such as:

- whirlpools and portable whirlpool pumps
- sauna baths
- massage devices
- overbed tables
- elevators
- communication or vision aids
- telephone alert systems

Early Acquired Disorder

Means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

Eligible Charge

A Provider's claim charge for Covered Services when a Provider has a written agreement with BCBSIL or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, and in the case of a Provider that does not have a written agreement with BCBSIL or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- the Provider's billed charges; or
- BCBSIL's non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) that is/are based on information on the claim

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the non-participating Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) that is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the claim, the Eligible Charge for non-participating Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

BCBSIL will utilize the same claim processing rules and/or edits that it utilizes in processing participating Provider claims for processing claims submitted by non-participating Providers which may also alter the Eligible Charge for a particular service. In the event BCBSIL does not have any claim edits or rules, BCBSIL may utilize the Medicare claim rules or edits that are used by Medicare in processing claims. The Eligible

Charge will not include any additional payments that may be permitted under Medicare laws or regulations that are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the Maximum Allowance amount does not equate to the non-participating Provider's claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable copayment, coinsurance, and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by BCBSIL within 190 days after the effective date that such change is implemented by the Centers for Medicaid & Medicare Services, or its successor.

Emergency Services

Medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a condition that requires immediate medical care or attention to prevent death, permanent dysfunction, significant impairment or serious medical complications, or, in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of emergency situations include:

- burns, cuts and broken or fractured bones
- seizures or loss of consciousness
- severe allergic reactions
- shortness of breath, chest pains or severe squeezing sensations in the chest
- suspected overdose of medication or poisoning
- sudden paralysis or slurred speech
- uncontrolled bleeding

Experimental/Investigational or Unproven Services and Supplies

Any medical, surgical, diagnostic, psychiatric, substance abuse, dental or other health care services, technologies, screenings, supplies, treatments, procedures, drug therapies or devices that are:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by an institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a Phase One, Two or Three clinical trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight;
- not of proven benefit or not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
- not a Covered Service as defined by the Plan

If you have a life-threatening illness (one that is likely to cause death within one year of the request for treatment), BCBSIL may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Service for that illness or condition. For this to occur, the service must use a specific research protocol that meets standards defined by the National Institutes of Health.

Generic Drug

A chemical equivalent of a Brand-Name Drug for which the patent has expired. The color or shape may be different, but the active ingredients in a Generic Drug must be the same as in its Brand-Name equivalent.

Habilitative Services

Means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an eligible person keep, learn, or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a child who is not walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this SPD.

Health Savings Account (HSA)

An individual account the Company funds annually for each associate enrolled in the Company Medical Plan and is used to pay for eligible medical and pharmacy expenses until it is exhausted. With the HSA, you have the option of also contributing to the account. Per the IRS, for 2024 the maximum amount you can contribute to an HSA is $4,150 for individual coverage or $8,300 for family coverage. If you are age 55 or older in 2024, you can make a catch-up contribution of $1,000 to your HSA. Unused HSA funds from one calendar year roll over to the next Plan year. **Note:** If you enroll in Company medical coverage, you cannot enroll in a general purpose Health Care Flexible Spending Account.

Home Health Agency

An agency, program or entity that:

- mainly provides skilled nursing and other therapeutic services in the home for the treatment of a physical illness or accidental injury that requires medical supervision and treatment;
- meets licensing standards in the state or locality in which it operates;
- is associated with a professional group under the supervision of at least one full-time Physician or licensed nurse;
- keeps complete medical records on each patient;
- has a full-time administrator; and
- is approved by The Joint Commission on Accreditation of Healthcare Organizations or Medicare

Hospice Care

Care given to a Terminally Ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care program.

Hospice Care Agency

An agency or organization that:

- assesses the patient's medical and social needs and develops a program to meet those needs;
- meets licensing or certification standards in its jurisdiction;
- has at least one Physician, licensed nurse, certified social worker and pastoral (or other) counselor on staff;
- keeps medical records on each patient;
- has a full-time administrator;
- has Hospice Care available 24-hours a day;
- provides skilled nursing services, medical social services, psychological and dietary counseling, and other services, which will include:
  - services of a Physician;
  - physical and occupational therapy;
  - part-time home health aide services that mainly consist of caring for Terminally Ill persons; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management
- provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency;
- permits all area medical personnel to utilize its services for their patients; and
- utilizes volunteers trained in providing services for non-medical needs

Hospice Facility

Facility that:

- mainly provides Inpatient palliative, supportive and other care to Terminally Ill persons;
- meets any licensing or certification standards set forth by its jurisdiction;
- has at least one Physician, licensed nurse, and certified social worker on staff;
- keeps medical records on each patient;
- has a full-time administrator;
- is not primarily a rest home, home for the aged, substance abuse treatment facility, or an educational or Custodial Care center;
- charges its patients; and
- provides an ongoing quality assurance program, this includes reviews by Physicians other than those who own or direct the facility

Hospital

A short-term, acute care facility that:

- is primarily engaged in providing Inpatient diagnostic and medical services or the care or treatment of sick and injured persons;
- meets any licensing or certification standards set forth by its jurisdiction;
- is supervised by a staff of Physicians and has organized departments of medicine;
- provides 24-hour a day nursing service by, or supervised by, registered nurses;
- is not primarily a rest home, home for the aged, substance abuse treatment facility, Skilled Nursing Facility, spa, or sanitarium, or an educational or Custodial Care center; and
- is approved by The Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by BCBSIL

Hospital Indemnity Insurance

Hospital Indemnity Insurance is a type of supplemental health insurance that provides financial protection by paying a fixed amount for each day an individual is hospitalized. It helps cover out-of-pocket expenses associated with hospital stays, such as deductibles, co-pays, and other non-covered services, or with daily living expenses like rent or groceries.

In-Network

A group of Physicians, pharmacies and other health care Providers who participate in a network and agree to charge negotiated rates to members who use the network.

Inpatient

Describes a person who is treated as a registered overnight bed patient in a facility, or care for that person.

Long Term Care

Means those social services, personal care services and/or Custodial Care services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

Maintenance Care

Means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy

Means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maximum Allowance

- the amount that participating Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by participating Providers will be based on the Schedule of Maximum Allowances that these Providers have agreed to accept as payment in full;
- for non-participating Providers, the Maximum Allowance will be the lesser of:
  - the Provider's billed charges; or
  - BCBSIL non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 300% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) that is/are based on information on the claim

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the non-participating Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) that is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined using the information submitted on the claim, the Maximum Allowance for non-participating Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

BCBSIL will utilize the same claim processing rules and/or edits that it utilizes in processing participating Provider claims for processing claims submitted by non-participating Providers which may also alter the Maximum Allowance for a particular service. In the event BCBSIL does not have any claim edits or rules, BCBSIL may utilize the Medicare claim rules or edits that are used by Medicare in processing claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations that are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the Maximum Allowance amount does not equate to the non-participating Provider's claim charge, you will be responsible for the difference between such amount and the claim charge, along with any applicable copayment, Coinsurance, and Deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by BCBSIL within 190 days after the effective date that such change is implemented by the Centers for Medicaid & Medicare Services, or its successor.

Medically Necessary

Means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician or Provider may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

Member Responsibility

This is the portion of the Deductible that a Covered Person must pay out-of-pocket. The Member Responsibility plus the amount the Company funds an HSA make up the annual Deductible.

Mental Illness

Means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Out-of-Pocket Maximum

The total amount a Covered Person is required to pay within a calendar year, including amounts paid toward medical and pharmacy expenses that applied toward the Deductible and as part of Coinsurance. Separate Out-of-Pocket Maximums apply to In-Network and out-of-network services.

Outpatient

Describes a person who receives services or supplies while not an Inpatient, or care for that person.

Physician

A licensed medical practitioner who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery. It also includes any other licensed medical practitioner whose services are required to be covered by law if he/she is:

- operating within the scope of his/her license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician

Physician Assistant

A duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of their license.

Precertification

When required, Precertification review evaluates the medical necessity, including the medical appropriateness of the setting, of proposed services for coverage under the Covered Person's benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. Precertification review may be initiated by a Physician or Provider, however, it is the Covered Person's responsibility to obtain Precertification review. Where Precertification review is required, BCBSIL's determination of coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for medical appropriateness of the requested procedure setting (e.g., Inpatient, short procedure unit, or Outpatient setting), other elements of the medical appropriateness/medical necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing Provider. Precertification review is not required for Emergency Services. The following are general examples of current Precertification review requirements under the Company Medical Plan; however, these requirements are subject to change: hysterectomy, nasal surgery procedures, bariatric surgery, potentially cosmetic or Experimental/Investigational procedures.

Prescription Drug

A drug that:

- has been approved by the Food and Drug Administration for safety and efficacy;
- has been approved under the Drug Efficacy Study Implementation review; or
- was marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order, or injectable insulin

Preventive Care

Services or supplies that are preventive in nature. The Plan pays 100% of eligible In-Network Preventive Care expenses (such as annual routine physical exams and mammograms). A list of eligible Preventive Care is available from BCBSIL at **1-877-239-7449** or **bcbsil.com**.

Private Duty Nursing Service

Means Skilled Nursing service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care service.

Provider

A facility or individual, licensed where required.

Qualified ABA Provider

Means a Provider operating within the scope of his/her license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor or Medicine (MD) prescribes ABA, writes an MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, or a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

Reasonable and Customary (R&C) Charge

Reasonable and Customary (R&C) charges and fees are charges or fees that do not exceed the prevailing charges for comparable services in your provider's area. The Claim Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. BCBSIL calculates R&C charges for out-of-network Providers based on 300% of the Medicare fee schedule.

The Plan does not cover amounts charged by out-of-network Providers in excess of the R&C charge for any service or supply. The Claim Administrator regularly reviews the R&C charge schedule. To confirm whether your provider's charges are within the R&C limit, be sure to get a Predetermination of Benefits.

Note that the R&C charge does not apply to specific services per the Consolidated Appropriations Act of 2021 (CAA); cost share is based on the median contracted rate and the Plan covers the full amount.

- Services provided by certain out-of-network providers at an In-Network facility
- Out-of-network air ambulance services
- Out-of-network emergency services

Reconstructive Surgery

Surgery that is incidental to an injury, illness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved body part. When a physical impairment exists and the surgery improves function, the fact that the physical appearance may change or improve as a result of the surgery does not classify it as cosmetic. Surgery to relieve psychological consequences or socially avoidant behavior as a result of an injury, illness or congenital anomaly will not be classified as reconstructive.

Rehabilitation Program

Inpatient and Outpatient substance abuse treatment is covered if the treatment is part of a Rehabilitation Program that:

- is prescribed and supervised by a Physician; and
- includes a follow-up therapy program at least once a month (or includes meetings at least twice a month with organizations devoted to treating the condition)

Effective treatment does not include detoxification (mainly treating the after effects of a specific episode of alcoholism or drug abuse) or maintenance care in a drug-free environment.

Sickness — For Medical Insurance

A physical or mental illness, including pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Care Services

Nursing, teaching and rehabilitation services that are:

- delivered or supervised by licensed technical or professional medical personnel to obtain a specified medical outcome and provide for the safety of the patient;
- ordered by a Physician; and
- necessary for the treatment of an accidental injury, illness or pregnancy

Determination of benefits for Skilled Care Services is made based on both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because a caregiver is not available.

Skilled Nursing Facility

A nursing facility, Hospital or special unit of a Hospital designated as an Inpatient facility that:

- provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis as permitted by law;
- is supervised by Physicians and provides nurses' services; and
- meets any licensing or certification standards in accordance with the laws of its jurisdiction

Speech Therapy

Means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Substance Use Disorder

Means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Surgery

Means the performance of any medically recognized, non-investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Claim Administrator.

Terminal Illness/Terminally Ill

A Terminal Illness will be considered to exist if a person becomes Terminally Ill with a prognosis of six months or less to live, as diagnosed by a Physician.