

BENEFIT BOOKLET to the COOK GROUP HEALTH PLAN MANUAL

**Clinic PPO Plan, Traditional PPO Plan, and High
Deductible Health Plan Options**

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COOK GROUP HEALTH PLAN

BENEFIT BOOKLET FOR CLINIC PPO PLAN, TRADITIONAL PPO PLAN, and HIGH DEDUCTIBLE HEALTH PLAN OPTIONS

This is a summary of your benefits as an employee. If you need more detailed information, visit www.cookmedicalclaims.com to view or print a copy of the Cook Group Health Plan Manual (Plan Manual) or ask your HR department for the complete Plan Manual or for the applicable sections of the Plan Manual that pertain to your questions. If there is an inconsistency between this summary and the Plan Manual, the Plan Manual will be the controlling document.

ELIGIBILITY

Article I in Plan Manual

Who Is Eligible?

- **New employees**
 - Full-time employees - if classified as a full-time employee, unless otherwise excluded, become eligible after completing a 30 day waiting period.
 - Seasonal and variable hour employees - if classified as a seasonal or variable hour employee and work at least 1560 hours during first twelve months of employment (the Initial Measurement Period), become eligible on first anniversary; remain eligible during next twelve months (Initial Stability Period), regardless of how many hours worked.
 - Seasonal = customary annual employment is 6 months or less, and employment is tied to a season

- Variable hour = at start date don't know whether employee will work 1560 hours because hours are variable or uncertain
- **Ongoing employees (after being employed for a full calendar year)**
 - Full-time employees - if classified as a full-time employee, unless otherwise excluded, remain eligible for coverage to the end of the year.
 - Seasonal and variable hour employees - must work 1560 hours during each calendar year (Standard Measurement Period) to be eligible for coverage during the next calendar year (Standard Stability Period); remain eligible during the Standard Stability Period, regardless how much work.
- **Non-employee directors.** A non-Employee director and the non-Employee director's eligible Spouse and Children.
- **Grandfathered director emeritus.** A director or non-Employee director who becomes a director emeritus before January 1, 2025, and is a Covered Person when the individual becomes such director emeritus. Their Spouse and Children are also eligible for benefits under the Plan similar to a non-employee director.
- **Spouse.** A Spouse (an individual of the same gender or opposite gender who is legally married to an employee, or non-employee director, and not legally separated from the employee, or non-employee director), if employee, or non-employee director are covered.
- **Child.** A Child (natural born, adopted, step, foster, or under guardianship of the employee, non-employee director, or under Qualified Medical Child Support Order) until the end

of the month in which they turn 26, if employee, or non-employee director are covered.

Who Is Not Eligible?

- Employees who do not work enough hours, and persons classified by their employer as leased employees or as independent contractors.
- Employees classified as not eligible.
- Spouses who are eligible to enroll in a major medical plan offered by their own current or former employer (including under COBRA) if the monthly premium cost for single coverage is less than \$250.

What Plan Options Are Available?

- All employees can enroll in the Clinic PPO Plan and the High Deductible Health Plan option.
- If you live outside Monroe County, Indiana, you can also enroll in the Traditional PPO Plan option, in addition to the High Deductible Health Plan option.
- You generally cannot change plan options during the year unless you move into or out of Monroe County, Indiana, or a special enrollment event occurs.

When Can You Enroll In The Plan?

Articles II and III in Plan Manual

- **New Full-Time Employees:** You can enroll yourself, your spouse (if eligible), and your children within 30 days from your date of hire. Your coverage, if elected, will be effective 30 days after your date of hire.
- **New Seasonal and Variable Hour Employees:** You can enroll yourself, your spouse, and your children effective on

your first anniversary, if you enroll within 30 days after your anniversary.

- **Ongoing Full-Time, Seasonal and Variable Hour Employees:** You can enroll yourself, your spouse, and your children effective on January 1 of any year.
- **Non-employee directors:** You can enroll yourself, your spouse and your children immediately upon commencement of service as a non-employee director if you apply for coverage within 30 days after beginning service as a non-employee director. If you do not apply for coverage within 30 days, then your right to coverage is forever forfeited. If you are a grandfathered director emeritus then you may continue your coverage in the Plan, and your eligible spouse and children who are covered persons at that time may also continue their coverage in the Plan. For clarification purposes, no individual will become a grandfathered director emeritus after January 1, 2025, and no Plan coverage is provided to any “non” grandfathered director emeritus.
- **Annual Open Enrollment:** You can enroll during open enrollment which generally occurs during November. Some open enrollments may be “passive” enrollments, meaning that if you do nothing, your current coverage elections will rollover to the next year. You can add or drop coverage or change options. Your coverage is effective January 1 of the next year.
- **Special Enrollment:** You may be able to add or drop coverage, change tiers or change options during a year if you request a change within 30 days (or 60 days where indicated) of one of the following events:

--You lose eligibility for your spouse’s or child’s coverage,

- Your spouse's or child's employer stops paying toward premiums for the coverage,
- You have a new spouse or child through marriage, birth or adoption,
- You lose Medicaid or Children's Health Insurance Program (CHIP) coverage (you have 60 days to request a change), or
- You become eligible for premium assistance from the state through Medicaid or CHIP (you have 60 days to request a change).
- **Other Mid-Year Enrollment Rights:** You may be able to add or drop coverage or change tiers, but generally cannot change options, if one of the following occurs:
 - A court orders coverage in connection with a divorce, legal separation, annulment or custody matter,
 - You have a mid-year change in cost or coverage under this plan or your spouse's or child's plan,
 - You, your spouse's, or your child's employment changes,
 - Open enrollment occurs at your spouse's or your child's employer, or
 - As permitted under the Cook Cafeteria Plan.

Coverage is generally effective for mid-year enrollments on the 1st of the month following the enrollment event. A completed enrollment or change form must be received by the Cook Insurance Department prior to the effective date.

Is a Newly Eligible Person Subject to a Preexisting Condition Limitation?

Section 7.1 in Plan Manual

No. There are no Preexisting Condition limitations in the plan.

CLINIC PPO PLAN OPTION

Clinic PPO Plan option participants must use the Cook Clinic for their primary care and purchase their prescription drugs, or receive their primary care from an approved primary care Physician located outside the Cook Clinic (while still purchasing prescription drugs at the Cook Clinic). For services above and beyond primary care services, participants must use a network provider to receive maximum benefits under the health plan. The health plan utilizes the Blue Cross Blue Shield Blue Card PPO network as the provider network.

However, Clinic PPO Plan option participants may do any of the following:

- use any physician or nurse practitioner at the Clinic;
- go to any network pediatrician for primary care up to the age of 16, without preauthorization or referral;
- seek obstetrical or gynecological care from any network obstetrician/gynecologist (OB/GYN), without preauthorization or referral;
- seek primary care from a non-Clinic primary care physician who has been authorized to provide primary care to Clinic PPO Plan option participants; and
- seek specialty care from a non-primary care network specialist, without preauthorization or referral.

The pediatrician, OB/GYN physician, authorized primary care physician and non-primary care specialist must comply with the

plan's procedures regarding pre-authorizations. For a list of primary care physicians, network pediatricians, OB/GYN physicians and specialist physicians, visit www.anthem.com.

TRADITIONAL PPO PLAN AND HIGH DEDUCTIBLE HEALTH PLAN OPTIONS

The Traditional PPO Plan and the High Deductible Health Plan options utilize one medical provider network. Members must use medical providers in the Blue Cross Blue Shield Blue Card PPO network to receive network benefits.

- Referrals are not required to see a specialist.
- Pre-authorizations are required per the plan for specified services.
- Members must use the TrueScripts pharmacy network or the Clinic pharmacy to receive network prescription drug benefits.

CONTACT INFORMATION

For medical network provider locators:

Employees residing in all states visit www.anthem.com or call 800.810.2583 to locate Blue Cross Blue Shield Blue Card network providers.

Send claims to:

Cook Group Health Plan, P.O. Box 1029, Bloomington, IN 47402-1029 or email itemizedbill@cookmedical.com
CookInsuranceGroup@cookmedical.com
Tel. 800.593.2080 or 812.355.2528

For health plan benefits and claim questions:

Cook Insurance Department
Monday - Friday 7:30 am to 4:00 pm EST
Tel. 800.593.2080

For Clinic PPO Plan option primary care:

Cook Family Health Center, 402 N. Rogers, Bloomington, IN 47404
Tel. 812.330.9944

For Clinic Pharmacy:

Cook Family Health Center Pharmacy, 402 N. Rogers,
Bloomington, IN 47404
Tel. 812.337.6162

For pharmacy benefit manager for prescription drugs and locating network pharmacies:

See “pharmacy” telephone number on health plan ID card
TrueScripts Management Services, P.O. Box 921, Washington, IN 47501
Tel. 844.257.1955 or visit www.truescripts.com

For dental claims, dental benefit questions and locating network dentists:

Delta Dental, P.O. Box 9085, Farmington Hills, MI 48333-9085
Tel. 800.524.0149 or visit www.deltadentalin.com

For vision claims, vision benefit questions, and locating vision network providers in all states:

Anthem Blue View Vision

www.anthem.com or call 1.866.723.0515

For preauthorization and case management:

Hines & Associates 800-944-9401

hinesassoc.com/provider-portal

General benefit questions:

Local HR or Benefits Department

Tel. 800-593-2080

CLINIC PPO PLAN OPTION SCHEDULE OF BENEFITS

Medical Benefits		
Cost Sharing		
<i>Section 8.1 in Plan Manual</i>		
The following deductibles, maximums and limits apply to the services listed in the schedule of benefits unless otherwise noted.		
Medical Deductible	Network	Out-of-Network
Individual (per calendar year)	\$500	\$500
Family (per calendar year)	\$1,000	\$1,000
There is a separate deductible for network charges and out-of-network charges. Network charges apply only toward the network deductible. Out-of-network charges apply only toward the out-of-network deductible.		
Charges for the following <u>do not</u> apply toward the medical deductible: prescription drugs, dental services, vision services, copayments, charges that apply toward other deductibles, second and third surgical opinion charges and non-covered services. No more than \$500 on any one individual applies toward the family deductible.		
Annual Out-of-Pocket Maximum	Network	Out-of-Network
Individual (per calendar year)	\$2,000 (includes deductibles)	No limit
Family (per calendar year)	\$4,000 (includes deductibles)	No limit
Charges for the following <u>do not</u> apply toward the annual out-of-pocket maximum: dental benefits, adult vision benefits, family planning, charges in excess of allowed amounts, non-covered services, amounts reimbursed through the pharmacy benefit manager Specialty Care Assistance Program and charges from out-of-network providers.		
There is no annual out-of-pocket maximum for out-of-network services.		

Annual Out-of-Pocket Maximum		
When you have met your out-of-pocket maximum, for the remainder of the year you will no longer have office visit copays, deductibles or coinsurance for covered network medical services and covered prescription drugs.		
Physician Office Services <i>Section 9.16 in Plan Manual</i>	Clinic/ Network	Out-of-Network
Clinic Visits	\$15 copayment	Not applicable
Lab Work (at Clinic or approved Primary Care)	100%	Not applicable
Specialist Office Visit	\$15 copayment	60% after deductible
Specialist office surgery, X-rays and lab tests	80% after deductible	60% after deductible
Pediatrician and Family Practitioner Office Visit until age 16	\$15 copayment	60% after deductible
Primary care outside Clinic age 16 and above*	Not covered	Not covered
*Note: Primary care at network OB/GYN provider or approved Primary Care provider is treated the same as Clinic visit.		
Preventive Care <i>Section 9.17 in Plan Manual</i>	Clinic/ Network	Out-of-Network
Annual Physical Exam • Including lab services	100%	60% after deductible
Annual Gynecological Exam • Including pap smear	100%	60% after deductible
Well-Baby and Child Care	100%	60% after deductible
Routine Childhood Immunizations	100%	60% after deductible
HPV Immunization • For males and females ages 9 - 26	100%	60% after deductible
Specified Adult Immunizations	100%	60% after deductible

Preventive Care <i>Section 9.16 in Plan Manual</i>	Clinic/ Network	Out-of-Network
Meningococcal Immunization For college freshmen not previously vaccinated	100%	60% after deductible
Maternity Preventive Services - Including dependent child - Breast feeding support and counseling (including lactation support) - Breast feeding pumps and supplies (including double electric pumps and breast milk storage supplies)	100% 100% 100%	60% after deductible 60% after deductible 60% after deductible
Mammograms - Routine baseline mammogram for females ages 35 - 39 - Annual screens for females age 40 and older - Annual screens for females age 35 and older if you are in the high-risk category - Annual Magnetic Resonance Imaging (MRI) screens for certain high-risk persons	100%	60% after deductible
Prostate-Specific Antigen Test (PSA) - Annual screens for males age 50 and older - Annual screens for males age 45 and older if you are in the high-risk category	100%	60% after deductible
Screening Flexible Sigmoidoscopy	100%	60% after deductible

Once every 5 years for those age 45 and older		
Preventive Care <i>Section 9.16 in Plan Manual</i>	Clinic/Network	Out-of-Network
Screening Colonoscopy Once every 10 years for those age 45 and older	100%	60% after deductible
Screening CT Colonoscopy Once every 5 years for those age 45 and older	100%	60% after deductible
Cologuard Colon Cancer Screening Once every 3 years for those age 45 and older	100%	60% after deductible
Contraceptive Services All FDA-approved contraceptives, sterilization procedures and education and counseling for women with reproductive capacity	100%	60% after deductible
Therapies <i>Section 9.22 in Plan Manual</i>	Network	Out-of-Network
Chiropractic Services Limited to 20 visits per person per calendar year	80% after deductible	60% after deductible
Physical, Occupational and Speech Therapy	80% after deductible	60% after deductible
Outpatient Infusion Therapy	80% after deductible	60% after deductible
Chemotherapy and Radiation Therapy	80% after deductible	60% after deductible
Mental Health and Substance Abuse Services <i>Section 9.14 in Plan Manual</i>	Network	Out-of-Network
Office Visits	\$15 copayment	60% after deductible
Transgender Therapy and Treatments	80% after deductible	60% after deductible
Inpatient, Outpatient, and Transitional Services, Supplies and Testing	80% after deductible	60% after deductible

Residential Treatment for Behavioral Health	80% after deductible	60% after deductible
Family Planning Services* <i>Section 9.8 in Plan Manual</i>	Network	Out-of-Network
Lifetime Maximum of \$25,000 per person**		
Primary Care and Specialist Office Visit	\$15 copayment	60% after deductible
Hospital Services	80% after deductible	60% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	60% after deductible
*All FDA-approved contraceptives and sterilization procedures and all education and counseling for women with reproductive capacity are no longer included in this Family Planning Benefit. See the Preventive Care Benefit section.		
**Any services in excess of this lifetime maximum are not covered charges. Infertility drugs are included in this lifetime maximum.		
Urgent Care Centers and Emergency Rooms <i>Sections 9.7 and 9.24 in Plan Manual</i>	Network	Out-of-Network
Urgent Care Centers	\$50 copayment, then 80% after deductible*	\$50 copayment, then 80% after deductible**
Emergency Room Visits	\$100 copayment, then 80% after deductible*	\$100 copayment, then 80% after deductible**
*If you are admitted to the hospital from the emergency room or an urgent care center, the copayment does not apply. If you are sent to the emergency room from an urgent care center and you are not admitted to the hospital, you pay only one copayment.		
**Emergency services in an urgent care center or hospital emergency room for an emergency medical condition will always be paid at the network level.		
Ambulatory Surgical Center <i>Section 9.3 in Plan Manual</i>	Network	Out-of-Network
Professional Services	80% after deductible	60% after deductible

Facility Charge	80% after deductible	60% after deductible
Hospital Inpatient and Outpatient Services, including mental health and substance abuse services <i>Section 9.12 in Plan Manual</i>	Network	Out-of-Network
Hospital and Hospital-Based Services and Supplies	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Facility Charges and Supplies	80% after deductible	60% after deductible
Diagnostic Procedures, for example: Computerized Tomography (CT) Scans Computerized Tomography Angiography (CTA) Magnetic Resonance Imaging (MRI) and Angiography (MRA) Positron Emission Tomography (PET) Electroencephalogram (EEG) Electrocardiogram (EKG) X-rays and Ultrasounds	80% after deductible	60% after deductible
Lab Tests	80% after deductible	60% after deductible
Other Services <i>Article IX in Plan Manual</i>	Network	Out-of-Network
Ambulance	80% after deductible	80% after deductible
Air Ambulance	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Foot Orthotics (if authorized)	80% after deductible	60% after deductible

Hearing checks, hearing aids (monaural or binaural), hearing aid instruments, batteries, cords, and supplies limited to \$3,000 maximum benefit per person every 5 years	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Other Services <i>Article IX in Plan Manual</i>	Network	Out-of-Network
Medical Supplies Including catheters, colostomy bags, rings and belts, flotation pads, and one insulin infusion pump each calendar year	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Skilled Nursing Facility Including private duty nursing	80% after deductible	60% after deductible
Support Hose - By prescription - Two pair per calendar year	80% after deductible	60% after deductible
Temporomandibular Joint Dysfunction (TMJ) Must be medically necessary	80% after deductible	60% after deductible
Wigs - If required due to cancer or related illness - One per illness, unless approved	80% after deductible	60% after deductible
Transplants <i>Section 9.23 in Plan Manual</i>	Heart, lung, bone marrow, liver, pancreas and kidney transplants are covered. See the Plan Manual for more information.	

Clinic PPO Plan Option Prescription Drug Schedule of Benefits <i>Article X in Plan Manual</i>		
Pharmacy deductible (per family per calendar year) is \$300. There is only one pharmacy deductible for Clinic and Non-Clinic Network charges. All Clinic and Non-Clinic Network charges apply toward this pharmacy deductible. Pharmacy drug benefits count toward the out-of-pocket maximum. Prescription drugs purchased at an Out-of-Network pharmacy are not Covered Charges.		
Prescription Drugs	Clinic Pharmacy	Non-Clinic Network Pharmacy
For generic drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply See Clinic Pharmacy prescription drug fee schedule below	After deductible, you pay 50%. But if drug is not available at Clinic, or you live outside Monroe County, or you were on vacation outside Monroe County, or the Clinic Pharmacy was closed, or the PBM approves, then the Clinic Pharmacy deductible, coinsurance and fee schedule apply.
For brand name drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply Plus you may pay the difference in cost between the brand name and generic drug.*	After deductible, you pay 50%. But if drug is not available at Clinic, or you live outside Monroe County, or you were on vacation outside Monroe County, or the Clinic Pharmacy was closed, or the PBM approves, then the Clinic Pharmacy deductible, coinsurance and fee schedule apply.

Prescription Drugs	Clinic Pharmacy	Non-Clinic Network Pharmacy
	See Clinic Pharmacy prescription drug fee schedule below	Plus you may pay the difference in cost between the brand name and generic drug.*
*If the prescriber writes a prescription for a brand name drug and indicates “Dispense as Written” on the prescription, there is no additional charge for the cost difference between the brand name drug and the generic drug. However, if the prescriber allows a generic drug to be dispensed, but you choose a brand name drug rather than the generic equivalent, you will be responsible for the brand name drug coinsurance, plus the cost difference between the brand name drug and the generic drug. Additionally, only the amount you would have paid had you accepted the generic drug will apply toward your drug deductible and out-of-pocket maximum. Certain classes of medications are subject to Step Therapy where a covered person who is using the drug for the first time must try a generic medication before purchasing a brand name medication, unless a prior authorization is approved from the prescriber.		
Prescription Drugs	Clinic Pharmacy and Non-Clinic Network Pharmacy	Non-Network Pharmacy
For specialty drugs	After deductible, you pay 20%	Not covered
The specialty drug network is subject to change. Contact the pharmacy benefit manager at the telephone number on your ID card to confirm network status of pharmacy and list of specialty drugs.		
Specialty drugs that qualify for the Specialty Care Assistance Program will be assigned to Tiers 1 – 5 and paid as indicated, after pharmacy deductible: - Tier 1 20% coinsurance up to \$100 maximum - Tier 2 20% coinsurance up to \$550 maximum; up to \$100 after processing - Tier 3 20% coinsurance with no maximum; up to \$100 after processing - Tier 4 50% coinsurance; up to \$100 after processing - Tier 5 Not Covered, but Specialty Care Assistance Program may be available		

Prescription Drugs	Clinic Pharmacy	Non-Clinic Network Pharmacy
Diabetic Supplies • Syringes, test strips, insulin, glucose meters, spacers, peak flow meters, counseling with a dietician	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply	After deductible, you pay 50%. But if supply not available at Clinic, or you live outside Monroe County, or you were on vacation outside Monroe County, or the Clinic Pharmacy was closed or PBM approves, then the Clinic Pharmacy deductible and coinsurance apply.
Smoking Cessation • Up to 84-day supply in 365 calendar days • Must be prescribed for use within 12 weeks	Plan pays 100% without deductible or coinsurance	After deductible, you pay 50%. But if not available at Clinic, or you live outside Monroe County, or you were on vacation outside Monroe County, or the Clinic Pharmacy was closed, or the PBM approves, then Plan pays 100% without deductible or coinsurance.
Sexual Dysfunction Drugs • Limited to 6 pills per 30 days	After deductible, you pay 20%	After deductible, you pay 50%. But if not available at Clinic, or you live outside Monroe County or you were on vacation outside Monroe County, or the Clinic Pharmacy was closed, or the PBM approves, then you pay 20%.

The price schedule at the Clinic Pharmacy is follows:

1-30 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible (for Traditional PPO Plan Option only):	Coinsurance After Satisfy Deductible:
	\$0 to \$9.99	\$5	\$1
	\$10 to \$14.99	\$10	\$2
	\$15 to \$19.99	\$15	\$3
	\$20 to \$24.99	\$20	\$4
	\$25 to \$29.99	\$25	\$5
	\$30 to \$34.99	\$30	\$6
	\$35 to \$39.99	\$35	\$7
	\$40 to \$44.99	\$40	\$8
	\$45 to \$49.99	\$45	\$9
	\$50 to \$54.99	\$50	\$10
	\$55 to \$59.99	\$55	\$11
	\$60 to \$299.99	\$60	\$12
	\$300 +	20% of cost	20% of cost to max \$100
31-60 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible (for Traditional PPO Plan Option only): :	Coinsurance After Satisfy Deductible:
	\$0 to \$19.99	\$10	\$2
	\$20 to \$29.99	\$20	\$4
	\$30 to \$39.99	\$30	\$6
	\$40 to \$49.99	\$40	\$8
	\$50 to \$59.99	\$50	\$10
	\$60 - \$69.99	\$60	\$12
	\$70 - \$79.99	\$70	\$14
	\$80 - \$89.99	\$80	\$16
	\$90 - \$99.99	\$90	\$18
	\$100 - \$109.99	\$100	\$20
	\$110 - \$119.99	\$110	\$22
	\$120 - \$599.99	\$120	\$24
	\$600 +	20% of cost	20% of cost to max \$200

61-90 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible(for Traditional PPO Plan Option only):	Coinsurance After Satisfy Deductible:
	\$0 to \$29.99	\$15	\$3
	\$30 to \$44.99	\$30	\$6
	\$45 to \$59.99	\$45	\$9
	\$60 to \$74.99	\$60	\$12
	\$75 to \$89.99	\$75	\$15
	\$90 to \$104.99	\$90	\$18
	\$105 to \$119.99	\$105	\$21
	\$120 to \$134.99	\$120	\$24
	\$135 to \$149.99	\$135	\$27
	\$150 to \$164.99	\$150	\$30
	\$165 to \$179.99	\$165	\$33
	\$180 to \$899.99	\$180	\$36
	\$900 +	20% of cost	20% of cost to max \$300

**TRADITIONAL PPO PLAN OPTION
SCHEDULE OF BENEFITS**

Medical Benefits		
Cost Sharing		
<i>Section 8.1 in Plan Manual</i>		
The following deductibles, maximums and limits apply to the services listed in the schedule of benefits unless otherwise noted.		
Medical Deductible	Network	Out-of-Network
Individual (per calendar year)	\$500	\$500
Family (per calendar year)	\$1,000	\$1,000
There is a separate deductible for network charges and out-of-network charges. Network charges apply only toward the network deductible. Out-of-network charges apply only toward the out-of-network deductible.		
Charges for the following <u>do not</u> apply toward the medical deductible: prescription drugs, dental services, vision services, copayments, charges that apply toward other deductibles, second and third surgical opinion charges, and non-covered services. No more than \$500 on any one individual applies toward the family deductible.		
Annual Out-of-Pocket Maximum	Network	Out-of-Network
Individual (per calendar year)	\$2,000 (includes deductibles)	No limit
Family (per calendar year)	\$4,000 (includes deductibles)	No limit
Charges for the following <u>do not</u> apply toward the annual out-of-pocket maximum: dental benefits, adult vision benefits, family planning, charges in excess of allowed amounts, amounts reimbursed through the pharmacy benefit manager Specialty Care Assistance Program, non-covered services and charges from out-of-network providers.		
There is no annual out-of-pocket maximum for out-of-network services.		

Annual Out-of-Pocket Maximum		
When you have met your out-of-pocket maximum, for the remainder of the year you will no longer have office visit copays, deductibles or coinsurance for covered network medical services and covered prescription drugs.		
Physician Office Services <i>Section 9.15 in Plan Manual</i>	Network	Out-of-Network
Office Visits Primary care* and specialists	\$15 copayment	60% after deductible
Office surgery, X-rays and lab tests by primary care* and specialists	80% after deductible	60% after deductible
*Traditional PPO Plan option participants may use the Cook Family Health Center for primary care.		
Preventive Care <i>Section 9.16 in Plan Manual</i>	Network	Out-of-Network
Annual Physical Exam Including lab services	100%	60% after deductible
Annual Gynecological Exam Including pap smear	100%	60% after deductible
Well-Baby and Child Care	100%	60% after deductible
Routine Childhood Immunizations	100%	60% after deductible
HPV Immunization For males and females ages 9 - 26	100%	60% after deductible
Specified Adult Immunizations	100%	60% after deductible
Meningococcal Immunization For college freshmen not previously vaccinated	100%	60% after deductible

Preventive Care <i>Section 9.16 in Plan Manual</i>	Network	Out-of-Network
Maternity Preventive Services • Including dependent child • Breast feeding support and counseling (including lactation support) • Breast feeding pumps and supplies (including double electric pumps and breast milk storage supplies)	100% 100% 100%	60% after deductible 60% after deductible 60% after deductible
Mammograms • Routine baseline mammogram for females ages 35 - 39 • Annual screens for females age 40 and older • Annual screens for females age 35 and older if you are in the high risk category • Annual Magnetic Resonance Imaging (MRI) screens for certain high risk persons	100%	60% after deductible
Prostate-Specific Antigen Test (PSA) • Annual screens for males age 50 and older • Annual screens for males age 45 and older if you are in the high risk category	100%	60% after deductible
Screening Flexible Sigmoidoscopy • Once every 5 years for those age 45 and older	100%	60% after deductible
Screening Colonoscopy • Once every 10 years for those age 45 and older	100%	60% after deductible

Screening CT Colonoscopy Once every 5 years for those age 45 and older	100%	60% after deductible
Cologuard Colon Cancer Screening Once every 3 years for those age 45 and older	100%	60% after deductible
Contraceptive Services All FDA-approved contraceptives, sterilization procedures and education and counseling for women with reproductive capacity	100%	60% after deductible
Therapies	Network	Out-of-Network
<i>Section 9.22 in Plan Manual</i>		
Chiropractic Services Limited to 20 visits per person per calendar year	80% after deductible	60% after deductible
Physical, Occupational and Speech Therapy	80% after deductible	60% after deductible
Outpatient Infusion Therapy	80% after deductible	60% after deductible
Chemotherapy and Radiation Therapy	80% after deductible	60% after deductible
Mental Health and Substance Abuse Services	Network	Out-of-Network
<i>Section 9.14 in Plan Manual</i>		
Office Visits	\$15 copayment	60% after deductible
Transgender Therapy and Treatments	80% after deductible	60% after deductible
Inpatient, Outpatient and Transitional Services, Supplies and Testing	80% after deductible	60% after deductible
Residential Treatment for Behavioral Health	80% after deductible	60% after deductible
Family Planning Services*	Network	Out-of-Network
<i>Section 9.8 in Plan Manual</i>		
Lifetime Maximum of \$25,000 per person**		
Primary Care and Specialist Office Visits	\$15 copayment	60% after deductible

Hospital Services	80% after deductible	60% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	60% after deductible
Family Planning Services* <i>Section 9.8 in Plan Manual</i>		
*All FDA-approved contraceptive and sterilization procedures and all education and counseling for women with reproductive capacity are no longer included in this Family Planning Benefit. See the Preventive Care Benefit section.		
**Any services in excess of this lifetime maximum are not covered charges. Infertility drugs are included in this lifetime maximum.		
Urgent Care Centers and Emergency Rooms <i>Sections 9.7 and 9.24 in Plan Manual</i>	Network	Out-of-Network
Urgent Care Centers	\$50 copayment, then 80% after deductible*	\$50 copayment, then 80% after deductible**
Emergency Room Visits	\$100 copayment, then 80% after deductible*	\$100 copayment, then 80% after deductible**
*If you are admitted to the hospital from the emergency room or an urgent care center, the copayment does not apply. If you are sent to the emergency room from an urgent care center and you are not admitted to the hospital, you pay only one copayment.		
**Emergency services in an urgent care center or hospital emergency room for an emergency medical condition will always be paid at the network level.		
Ambulatory Surgical Center <i>Section 9.3 in Plan Manual</i>	Network	Out-of-Network
Professional Services	80% after deductible	60% after deductible
Facility Charge	80% after deductible	60% after deductible

Hospital Inpatient and Outpatient Services, including mental health and substance abuse services <i>Section 9.12 in Plan Manual</i>	Network	Out-of-Network
Hospital and Hospital- Based Services and Supplies	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Facility Charges and Supplies	80% after deductible	60% after deductible
Diagnostic Procedures, for example: Computerized Tomography (CT) Scans Computerized Tomography Angiography (CTA) Magnetic Resonance Imaging (MRI) and Angiography (MRA) Positron Emission Tomography (PET) Electroencephalogram (EEG) Electrocardiogram (EKG) X-rays and Ultrasounds	80% after deductible	60% after deductible
Lab Tests	80% after deductible	60% after deductible
Other Services <i>Article IX in Plan Manual</i>	Network	Out-of-Network
Ambulance	80% after deductible	80% after deductible
Air Ambulance	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible

Other Services <i>Article IX in Plan Manual</i>	Network	Out-of-Network
Foot Orthotics (if authorized)	80% after deductible	60% after deductible
Hearing checks, hearing aids (monaural or binaural), hearing aid instruments, batteries, cords, and supplies limited to \$3,000 maximum benefit per person every 5 years	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Medical Supplies Including catheters, colostomy bags, rings and belts, flotation pads, and one insulin infusion pump each calendar year	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Skilled Nursing Facility Including private duty nursing	80% after deductible	60% after deductible
Support Hose - By prescription - Two pair per calendar year	80% after deductible	60% after deductible
Temporomandibular Joint Dysfunction (TMJ) Must be medically necessary	80% after deductible	60% after deductible
Wigs - If required due to cancer or related illness - One per illness, unless approved	80% after deductible	60% after deductible

Transplants <i>Section 9.23 in Plan Manual</i>	Heart, lung, bone marrow, liver, pancreas and kidney transplants are covered. See the Plan Manual for more information.
Traditional PPO Plan Option Prescription Drug Schedule of Benefits <i>Article X in Plan Manual</i>	
Pharmacy deductible (per family per calendar year) is \$300. There is only one pharmacy deductible for Clinic and Non-Clinic Network charges. All Clinic and Non-Clinic Network charges apply toward this pharmacy deductible. Pharmacy drug benefits count toward the out-of-pocket maximum. Prescription drugs purchased at an Out-of-Network pharmacy are not Covered Charges.	
Prescription Drugs	Clinic Pharmacy and Non-Clinic Network Pharmacy
For generic drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply
For brand name drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply Plus, you may pay the difference in cost between the brand name and generic drug*
*If the prescriber writes a prescription for a brand name drug and indicates “Dispense as Written” on the prescription, there is no additional charge for the cost difference between the brand name drug and the generic drug. However, if the prescriber allows a generic drug to be dispensed, but you choose a brand name drug rather than the generic equivalent, you will be responsible for the brand name drug coinsurance, plus the cost difference between the brand name drug and the generic drug. Additionally, only the amount you would have paid had you accepted the generic drug will apply toward your drug deductible and out-of-pocket maximum. Certain classes of medications are subject to Step Therapy where a covered person who is using the drug for the first time must try a generic medication before purchasing a brand name medication, unless a prior authorization is approved from the prescriber.	

Prescription drugs	Clinic Pharmacy and Non-Clinic Network Pharmacy	Non-Network Pharmacy
For specialty drugs	After deductible, you pay 20%	Not covered
The specialty drug network is subject to change. Contact the pharmacy benefit manager at the telephone number on your ID card to confirm network status of pharmacy and list of specialty drugs.		
Specialty drugs that qualify for the Specialty Care Assistance Program will be assigned to Tiers 1 – 5 and paid as indicated, after pharmacy deductible: - Tier 1 20% coinsurance to \$100 maximum - Tier 2 20% coinsurance up to \$550 maximum; up to \$100 after processing - Tier 3 20% coinsurance with no maximum; up to \$100 after processing - Tier 4 50% coinsurance; up to \$100 after processing - Tier 5 Not covered, but Specialty Care Assistance Program may be available		
Prescription Drugs	Clinic and Non-Clinic Network Pharmacy	
Diabetic Supplies Syringes, test strips, insulin, glucose meters, spacers, peak flow meters, counseling with a dietician	After deductible, you pay 20% up to: \$100 maximum per 30-day supply \$200 maximum per 60-day supply \$300 maximum per 90-day supply	
Smoking Cessation - Up to 84-day supply in 365 calendar days - Must be prescribed for use within 12 weeks	Plan pays 100% without deductible or coinsurance	
Sexual Dysfunction Drugs Limited to 6 pills per 30 days	After deductible, you pay 20%	

HIGH DEDUCTIBLE HEALTH PLAN OPTION SCHEDULE OF BENEFITS

Medical Benefits		
Cost Sharing		
<i>Section 8.1 in Plan Manual</i>		
The following deductibles, maximums and limits apply to the services listed in the schedule of benefits unless otherwise noted.		
Medical Deductible	Network	Out-of-Network
Individual (per calendar year)	\$1,700	\$1,700
Family (per calendar year)	\$3,400	\$3,400
There is a separate deductible for network charges and out-of-network charges. Network charges apply only toward the network deductible. Out-of-network charges apply only toward the out-of-network deductible.		
Charges for the following <u>do not</u> apply toward the medical deductible: dental services, vision services, copayments, charges that apply toward other deductibles, second and third surgical opinion charges, and non-covered services.		
Annual Out-of-Pocket Maximum	Network	Out-of-Network
Individual (per calendar year)	\$2,000 (includes deductibles)	No limit
Family (per calendar year)	\$4,000 (includes deductibles)	No limit
Charges for the following <u>do not</u> apply toward the annual out-of-pocket maximum: dental benefits, adult vision benefits, family planning, charges in excess of allowed amounts, amounts reimbursed through the pharmacy benefit manager Specialty Care Assistance Program, non-covered services and charges from out-of-network providers.		
There is no annual out-of-pocket maximum for out-of-network services.		

Annual Out-of-Pocket Maximum		
When you have met your out-of-pocket maximum, for the remainder of the year you will no longer have office visit copays, deductibles or coinsurance for covered network medical services and covered prescription drugs.		
Physician Office Services <i>Section 9.15 in Plan Manual</i>	Network	Out-of-Network
Office Visits Primary care* and specialists	<u>Outside of the Cook Family Health Center – 80% after deductible</u>	60% after deductible
	<u>At the Cook Family Health Center - \$30 copayment</u>	Not Covered
Office surgery, X-rays and lab tests by primary care* and specialists	80% after deductible	60% after deductible
*High Deductible Health Plan option participants may use the Cook Family Health Center for primary care.		
Preventive Care <i>Section 9.16 in Plan Manual</i>	Network	Out-of-Network
Annual Physical Exam Including lab services	100%	60% after deductible
Annual Gynecological Exam Including pap smear	100%	60% after deductible
Well-Baby and Child Care	100%	60% after deductible
Routine Childhood Immunizations	100%	60% after deductible
HPV Immunization For males and females ages 9 - 26	100%	60% after deductible
Specified Adult Immunizations	100%	60% after deductible
Meningococcal Immunization For college freshmen not previously vaccinated	100%	60% after deductible

Preventive Care <i>Section 9.16 in Plan Manual</i>	Network	Out-of-Network
Maternity Preventive Services • Including dependent child • Breast feeding support and counseling (including lactation support) • Breast feeding pumps and supplies (including double electric pumps and breast milk storage supplies)	100% 100% 100%	60% after deductible 60% after deductible 60% after deductible
Mammograms • Routine baseline mammogram for females ages 35 - 39 • Annual screens for females age 40 and older • Annual screens for females age 35 and older if you are in the high risk category • Annual Magnetic Resonance Imaging (MRI) screens for certain high risk persons	100%	60% after deductible
Prostate-Specific Antigen Test (PSA) • Annual screens for males age 50 and older • Annual screens for males age 45 and older if you are in the high risk category	100%	60% after deductible
Screening Flexible Sigmoidoscopy • Once every 5 years for those age 45 and older	100%	60% after deductible
Screening Colonoscopy	100%	60% after deductible

Once every 10 years for those age 45 and older		
Screening CT Colonoscopy Once every 5 years for those age 45 and older	100%	60% after deductible
Cologuard Colon Cancer Screening Once every 3 years for those age 45 and older	100%	60% after deductible
Contraceptive Services All FDA-approved contraceptives, sterilization procedures and education and counseling for women with reproductive capacity	100%	60% after deductible
Therapies <i>Section 9.22 in Plan Manual</i>	Network	Out-of-Network
Chiropractic Services Limited to 20 visits per person per calendar year	80% after deductible	60% after deductible
Physical, Occupational and Speech Therapy	80% after deductible	60% after deductible
Outpatient Infusion Therapy	80% after deductible	60% after deductible
Chemotherapy and Radiation Therapy	80% after deductible	60% after deductible
Mental Health and Substance Abuse Services <i>Section 9.14 in Plan Manual</i>	Network	Out-of-Network
Office Visits	<u>Outside of the Cook Family Health Center</u> – 80% after deductible <u>At the Cook Family Health Center</u> – \$30 copayment	60% after deductible Not Covered

Transgender Therapy and Treatments	80% after deductible	60% after deductible
Inpatient, Outpatient and Transitional Services, Supplies and Testing	80% after deductible	60% after deductible
Residential Treatment for Behavioral Health	80% after deductible	60% after deductible
Family Planning Services* <i>Section 9.8 in Plan Manual</i>	Network	Out-of-Network
Lifetime Maximum of \$25,000 per person**		
Primary Care and Specialist Office Visits	<u>Outside of the Cook Family Health Center</u> – 80% after deductible <u>At the Cook Family Health Center</u> - \$30 copayment \$30 copayment	60% after deductible Not Covered
Hospital Services	80% after deductible	60% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	60% after deductible
*All FDA-approved contraceptive and sterilization procedures and all education and counseling for women with reproductive capacity are no longer included in this Family Planning Benefit. See the Preventive Care Benefit section.		
**Any services in excess of this lifetime maximum are not covered charges. Infertility drugs are included in this lifetime maximum.		
Urgent Care Centers and Emergency Rooms <i>Sections 9.7 and 9.24 in Plan Manual</i>	Network	Out-of-Network
Urgent Care Centers	80% after deductible*	80% after deductible**
Emergency Room Visits	80% after deductible*	80% after deductible**
*If you are admitted to the hospital from the emergency room or an urgent care center, the copayment does not apply. If you are sent to the emergency room from an urgent care center and you are not admitted to the hospital, you pay only one copayment.		

**Emergency services in an urgent care center or hospital emergency room for an emergency medical condition will always be paid at the network level.		
Ambulatory Surgical Center <i>Section 9.3 in Plan Manual</i>	Network	Out-of-Network
Professional Services	80% after deductible	60% after deductible
Facility Charge	80% after deductible	60% after deductible
Hospital Inpatient and Outpatient Services, including mental health and substance abuse services <i>Section 9.12 in Plan Manual</i>	Network	Out-of-Network
Hospital and Hospital-Based Services and Supplies	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Facility Charges and Supplies	80% after deductible	60% after deductible
Diagnostic Procedures, for example: Computerized Tomography (CT) Scans Computerized Tomography Angiography (CTA) Magnetic Resonance Imaging (MRI) and Angiography (MRA) Positron Emission Tomography (PET) Electroencephalogram (EEG) Electrocardiogram (EKG) X-rays and Ultrasounds	80% after deductible	60% after deductible
Lab Tests	80% after deductible	60% after deductible

Other Services <i>Article IX in Plan Manual</i>	Network	Out-of-Network
Ambulance	80% after deductible	80% after deductible
Air Ambulance	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Foot Orthotics (if authorized)	80% after deductible	60% after deductible
Hearing checks, hearing aids (monaural or binaural), hearing aid instruments, batteries, cords, and supplies limited to \$3,000 maximum benefit per person every 5 years	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Medical Supplies Including catheters, colostomy bags, rings and belts, flotation pads, and one insulin infusion pump each calendar year	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Skilled Nursing Facility Including private duty nursing	80% after deductible	60% after deductible
Support Hose - By prescription - Two pair per calendar year	80% after deductible	60% after deductible
Temporomandibular Joint Dysfunction (TMJ) Must be medically necessary	80% after deductible	60% after deductible

Wigs	80% after deductible	60% after deductible
• If required due to cancer or related illness • One per illness, unless approved		
Transplants <i>Section 9.23 in Plan Manual</i>	Heart, lung, bone marrow, liver, pancreas and kidney transplants are covered. See the Plan Manual for more information.	
High Deductible Health Plan Option Prescription Drug Schedule of Benefits <i>Article X in Plan Manual</i>		
Pharmacy deductible is included with the annual medical deductible. Prescriptions charged at full price until medical deductible is met. There is only one pharmacy deductible for Clinic and Non-Clinic Network charges. All Clinic and Non-Clinic Network charges apply toward this pharmacy deductible. Pharmacy drug benefits count toward the out-of-pocket maximum. Prescription drugs purchased at an Out-of-Network pharmacy are not Covered Charges.		
Prescription Drugs	Clinic Pharmacy and Non-Clinic Network Pharmacy	
• For generic drugs	80% after deductible	
• For brand name drugs	80% after deductible*	
*If the prescriber writes a prescription for a brand name drug and indicates “Dispense as Written” on the prescription, there is no additional charge for the cost difference between the brand name drug and the generic drug. However, if the prescriber allows a generic drug to be dispensed, but you choose a brand name drug rather than the generic equivalent, you will be responsible for the brand name drug coinsurance, plus the cost difference between the brand name drug and the generic drug. Additionally, only the amount you would have paid had you accepted the generic drug will apply toward your drug deductible and out-of-pocket maximum. Certain classes of medications are subject to Step Therapy where a covered person who is using the drug for the first time must try a generic medication before purchasing a brand name medication unless a prior authorization is approved from the prescriber.		

Prescription drugs	Clinic Pharmacy and Non-Clinic Network Pharmacy	Non-Network Pharmacy
• For specialty drugs	80% after deductible	Not covered
Prescription Drugs	Clinic and Non-Clinic Network Pharmacy	
Diabetic Supplies • Syringes, test strips, insulin, glucose meters, spacers, peak flow meters, counseling with a dietician	80% after deductible	
Cessation • Up to 84-day supply in 365 calendar days • Must be prescribed for use within 12 weeks	80% after deductible	
Sexual Dysfunction Drugs • Limited to 6 pills per 30 days	80% after deductible	

VISION AND DENTAL SCHEDULE OF BENEFITS

This schedule of benefits applies to the Clinic PPO Plan, Traditional PPO, and High Deductible Health Plan options.

Vision Benefits	Network	Out-of-Network
Exam, frames, eyeglass lenses		
Routine eye exam — once every calendar year	Covered in full	\$42 allowance
Eyeglass frames — once every other calendar year	\$200 allowance, and 20% of balance	\$42 allowance
Eyeglass lenses (std. plastic) — once every calendar year		
Single vision lenses	Covered in full	\$40 allowance
Bifocal lenses	Covered in full	\$60 allowance
Trifocal lenses	Covered in full	\$80 allowance
Eyeglass lens enhancements		
Transition lenses (for a child under age 19)	100%	No allowance
Standard polycarbonate (for child under age 19)	100%	No allowance
Factory scratch coating	100%	No allowance
Contact lenses		
Once every calendar year in lieu of eyeglass lenses		
Elective conventional lenses; or	\$200 allowance, then 15% of balance	\$105 allowance
Elective disposable lenses; or	\$200 allowance	\$105 allowance
Non-elective lenses	Covered in full	\$210 allowance

Use the Anthem Blue View Vision providers for In-Network benefits or any qualified vision provider for Out-of-Network benefits.

Dental Benefits <i>Article XII in Plan Manual</i>	
Use Delta Dental network providers or any qualified dental provider, with no deductible	
Diagnostic and Preventive Services • Two exams, evaluations and cleanings per year • Bite-wing x-rays – one set per calendar year • Fluoride treatments – two per calendar year to age 19 • Oral brush biopsy and laboratory analysis • Not subject to calendar year maximum	Covered at 100% of charges
Basic Services • Calendar year maximum of \$1,500 per person • Including space maintainers, emergency palliative treatment (to temporarily relieve pain), sealants, radiographs (X-rays other than bitewing X-rays), minor restorative services (fillings and crown repair), endodontic services (root canals), periodontic services (to treat gum disease), oral surgery services (extractions and dental surgery), other basic services (miscellaneous services) and relines and repairs (to bridges, implants, and dentures)	Covered at 80% of charges
Major Services • Calendar year maximum of \$1,500 per person • Including crowns, bridges, implants, and dentures • Excluding extraction of impacted and semi-impacted teeth and orthodontia services	Covered at 50% of charges
Dental Implants • Not subject to calendar year maximum • Lifetime maximum of \$3,000 per person	Covered at 50% of charges
Extraction of Impacted and Semi-Impacted Teeth • Including wisdom teeth and anesthesia charges • Not subject to calendar year maximum • Not subject to medical deductible	Covered at 80% of charges
Orthodontia Services • Only for children under age 19 • Not subject to calendar year maximum • Lifetime maximum of \$1,500 per person	Covered at 50% of charges

COVERAGE AND CLAIMS

What Services Must Be Preauthorized?

Article VII in Plan Manual

If you or your out-of-network provider do not obtain the required preauthorization, a 100% penalty will apply and your out-of-pocket costs will increase. This does not apply to medically necessary inpatient facility services from a Blue Cross Blue Shield Blue Card network provider.

The following services require prior review and preauthorization by the plan in order for you to receive benefits:

1. Inpatient Services

- Surgical and nonsurgical admissions, including mental health and substance abuse admissions, that aren't emergency or maternity admissions
- Newborn stays beyond that of the mother
- Skilled nursing facility stays
- Acute rehabilitation facility stays
- Hospice care
- Residential treatment for behavioral health

2. Reconstructive or other procedures that may be considered cosmetic, including but not limited to:

- Blepharoplasty/canthopexy/canthoplasty
- Breast reconstruction/breast enlargement
- Breast reduction/mammoplasty
- Chemical peels

- Otoplasty
- Pectus excavatum repair
- Surgical treatment of gynecomastia
- Surgery for varicose veins

3. All outpatient surgeries and procedures, including but not limited to:

- Angioplasty
- Arthroscopy, e.g., shoulder/knee
- Back surgery
- Cholecystectomy
- D&C for termination of pregnancy
- Epidural facet injections for pain management
- Hernia procedures (except inguinal)
- Hysterectomy
- Hysterosalpingography
- Laparoscopy
- Mastectomy
- Oophorectomy
- Rhinoplasty
- Tunnel syndromes/decompressions

- Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures
- 4. **Bariatric surgery**
- 5. **Inpatient back surgery**
- 6. **Orthognathic (jaw and facial structure) surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint**
- 7. **Medical injectables, including but not limited to:**
 - Blood-clotting factors
 - Growth hormone
 - Interferons, when used for hepatitis C
 - Intravenous immunoglobulin (IVIG)
 - The following drugs, including any biological drugs, used in the treatment of rheumatoid arthritis, psoriasis and multiple sclerosis:¹
 - a. Acthar Gel® (for acute multiple sclerosis exacerbations)
 - b. Erbitux®
 - c. Erythropoiesis stimulating agents (ESA) such as darbepoetin alpha (Aranesp), epoetin alpha (Epogen and Procrit) and epoetin beta (Micera)

¹ *Acthar Gel is a registered trademark of Questcor Pharmaceuticals, Inc. Aranesp and Epogen are registered trademarks of Amgen Inc. Erbitux is a registered trademark of ImClone Systems Incorporated. Mircera is a registered trademark of Hoffmann-La Roche Inc. Procrit is a registered trademark of Johnson & Johnson.*

- d. Rituxan when used for rheumatoid arthritis
 - e. Synagis
 - f. Xolair
 - g. Vectibix®
8. **All specialty and compound prescription drugs**
 9. **All home healthcare services, including home uterine monitoring and home hospice**
 10. **Selected durable medical equipment, including (not an all-inclusive list):**
 - Electric or motorized wheelchairs and scooters
 - Limb prosthetics
 - Customized braces
 11. **All genetic testing, including genetic testing that is part of pregnancy preventive care**
 12. **Medically necessary orthodontia** – e.g., from congenital abnormalities, such as cleft palate or severe malocclusion
 13. **Applied behavioral analysis**
 14. **Outpatient infusion therapy**
 15. **Transgender therapies, treatments, and surgeries**
 16. **Organ or Tissue Transplants** - except for cornea transplants. As soon as indicated as potential candidate for transplant or donor, the pre-certification vendor must be contacted to begin pre-authorization for the initial evaluation and listing of the transplant. Failure to

preauthorize a transplant procedure will result in the application of the \$5,000 deductible to all covered charges resulting from the transplant. If a Network contract is terminated and an Organ Transplant treatment plan has begun and before benefits are exhausted, then Plan benefits will be paid for the same Organ Transplant expenses as though Network coverage had not ended.

- **For review and preauthorization, call Hines & Associates, 800-944-9401, hinesassoc.com/provider-portal**
- **Preauthorizations are valid for six months unless otherwise indicated at the time of preauthorization.**

What Happens If I Do Not Get the Above Services Preauthorized?

The plan will not pay benefits for those services, and charges will not apply to the out-of-pocket maximum. This does not apply to medically necessary inpatient facility services from a Blue Cross Blue Shield Blue Card network provider.

What Medical Services Are Covered?

Article VIII in Plan Manual

The plan will pay the benefits listed in the schedule of benefits and those in the Plan Manual, including benefits for the following:

- **Abortion**
 - As allowed under Indiana state law, abortion procedures performed only at a Hospital or Ambulatory Outpatient Surgical Center owned by a Hospital for a covered Employee or covered Spouse are covered under the following circumstances (i) a

Physician determines that the abortion is Medically Necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life, (ii) the fetus is diagnosed with a lethal fatal anomaly, or (iii) the pregnancy is a result of rape and incest and the abortion is provided within the first 10 weeks of the pregnancy.

- **Ambulance services**

Air ambulance services (including air ambulance services from an out-of-network provider, which will be provided at the same cost as network services including cost sharing)

- **Ambulatory surgical centers**

- **Anesthesia**

- **Bariatric surgery, if you qualify and all requirements of the Bariatric Surgery Policy are met (see Addendum F of the *Plan Manual*). Nutritional counseling, dietary counseling and weight loss services are Covered Charges for Covered Persons for whom bariatric surgery is a Covered Charge.**

- Patients should contact the Bariatric Coordinator at 812.330.5462 prior to scheduling any appointment relating to bariatric surgery. In addition to other requirements, patients must be ≥ 18 years of age or have reached full expected skeletal growth AND have documented evidence from their primary care provider that they have a Body Mass Index (BMI) ≥ 40 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease or obstructive sleep apnea. Clinic PPO Plan option participants who have had bariatric surgery under a prior plan

must obtain a referral for follow-up care with their surgeon and/or bariatric surgery center.

- **Breast Cancer Screening** including preventive care services set forth in the schedules of benefits, including but not limited to:
 - Digital breast tomosynthesis or 3D screening mammography
 - Additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation to complete the screening process for malignancies or to address findings on the initial screening mammography.
- **Durable medical equipment**
- **Emergency room services**
- **Family planning services** including:
 - diagnosis and treatment of Infertility, including, but not limited to:
 - artificial insemination, sperm washings, sperm banking and/or storage;
 - cryopreservation of semen;
 - embryo implants;
 - gamete intrafallopian transfer (“GIFT”);
 - in vitro fertilization (“IVF”);
 - medications for infertility and ultrasounds associated with infertility medication therapy;

- zygote intrafallopian transfer (“ZIFT”);
- hamster egg penetration tests;
- treatment of Sexual Dysfunction, including, but not limited to:
 - surgical procedures;
 - FDA-approved prescription drugs;
 - Prescribed devices and appliances;
 - Psychotherapy and counseling.
- voluntary sterilization, including, but not limited to vasectomy.

Excluded Charges. The following charges are excluded:

- egg or sperm donor costs;
- implantation;
- treatment of or support of a surrogate mother;
- reversal of elective or Medically Necessary sterilization;
- any treatments for infertility after voluntary sterilization, except in cases of ectopic pregnancy;
- treatment of Children, other than Preventive Care services for a pregnant Child; and
- in vitro procedures for pre-implantation genetic diagnoses.

All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and

counseling for all women with reproductive capacity, including Children, are covered as Preventive Care Services, instead of as Family Planning Services.

“*Infertility*” means the inability to conceive after twelve consecutive months of unprotected sexual intercourse.

“*Sexual Dysfunction*” means sexual dysfunction which is a result of: (a) a specific physically traumatic event; (b) organic disease (such as prostate cancer, diabetes mellitus, arterio sclerosis); or (c) the effects of surgery, radiation therapy or drug therapy.

Prescribed drugs are covered under the Prescription Drug benefits. Prescribed drugs, psychotherapy and counseling for Sexual Dysfunction do not count toward the Family Planning maximum benefit.

- **Foot orthotics and therapeutic shoes**

Foot orthotics and other supportive devices for the feet are not Covered Charges, except the following are Covered Charges:

- A shoe, if it is an integral part of a leg brace and its expense is included in the cost of the brace.
- Therapeutic shoes (depth or custom molded) along with inserts that are Medically Necessary and are not Experimental or Investigative for persons with diabetes mellitus and the following complications involving the foot:
 - peripheral neuropathy with evidence of callus formation;
 - history of pre-ulcerative calluses;
 - history of previous ulceration;
 - foot deformity;

- previous amputation of the foot or part of the foot; or
 - poor circulation.
- **Hearing checks, hearing aids (monaural or binaural), including ear mold(s), and hearing aid instrument, batteries, cords and other ancillary equipment, as required to correct hearing loss, up to \$3,000 per person every 5 years.** Out-of-network hearing aid services and supplies will be paid at the network benefit level, and out-of-network charges will apply toward the benefit maximum and toward the benefit maximum and toward the out-of-network maximum. Medically necessary surgically implanted hearing devices may be covered under the Cook Health Plan's medical benefits for prosthetic devices.
- **Home healthcare**
- **Hospice**
- **Hospital inpatient and outpatient services**
 - including room and board, hospital-based services, supplies, physician visits, diagnostic imaging and lab work
- **Maternity and newborn services**
- **Mental health and substance abuse services**
 - including inpatient, outpatient, transitional treatment programs, and ADD/ADHD services
- **Medical services provided by residential behavioral facilities**
- **Physician office visits, including physician office visits, lab work, and specialist office visits**

- **Prescription drugs as provided in this Booklet and the Plan Manual**
 - See Article X in the Plan Manual
- **Preventive care**
- **Second and third surgical opinion**
- **Skilled nursing facility**
- **Support hose**
- **Surgical services**
 - including oral surgery
- **Telehealth services including on-line and/or telehealth services, covered the same as in-person office visit.** For example, such on-line and/or telehealth services include, but are not limited to, patients use of smartphones, iPads, computers and similar devices to carry on live video chat with Providers about any coronavirus symptoms and other medical concerns. Any Copayments, Coinsurance and Deductibles will apply.
- **Temporomandibular joint dysfunction (TMJ), if medically necessary**
- **Therapies**
 - Chiropractic, physical, occupational, speech, radiation, outpatient infusion, and chemotherapy
 - Transgender therapies, treatments, and surgeries
- **Transplant of human organs and tissue**

Covered Transplants.

- Heart Transplant
 - Network – 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible, up to an overall Transplant Benefit Period maximum of \$110,000, and a Physician maximum of \$20,000
- Lung Transplant
 - Network - 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible, up to overall Transplant Benefit Period maximum of \$155,000, and a Physician maximum of \$20,000.
- Bone Marrow Transplant
 - Network - 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$130,000, and a Physician maximum of \$20,000.
- Liver Transplant
 - Network - 100% of Covered Charges after the Deductible;

- Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$130,000, and a Physician maximum of \$20,000.
- Heart/Lung Transplant
 - Network - 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$150,000, and a Physician maximum of \$20,000.
- Pancreas Transplant
 - Network - 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$70,000, and a Physician maximum of \$20,000.
- Kidney Transplant
 - Network - 100% of Covered Charges after the Deductible;
 - Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$55,000, and a Physician maximum of \$20,000.

- **Urgent care centers**
- **Wigs**
- **Other services as described in Section 9.26 in the Plan Manual**

What Medical Services Are Not Covered?

Section 9.28 in Plan Manual

The plan will not pay for the following expenses:

- Acupuncture.
- After-hours, weekend or holiday extra charges.
- Anorectics.
- Autologous blood donation and storage.
- Biofeedback.
- Corn and callus removal, toenail trimming and similar procedures.
- Cosmetic treatment or surgery, except when related to an accident and provided within two years of the accident, or when is to achieve normal body function or correct a congenital deformity.
- Court-ordered services, legally required services, or services ordered by an administrative agency, unless the injury or illness results from an act of domestic violence or a medical condition.
- Custodial care (care that is primarily to assist with the activities of daily living or meeting personal, rather than medical, needs), convalescent care and rest cures, whether or not recommended or performed by a professional.

- Child's pregnancy, delivery or complications from the pregnancy (but preventive care during pregnancy and prescribed contraceptives are covered).
- Egg and sperm donor costs, implantation, treatment or support of surrogate mother, procedures to reverse elective or medically necessary sterilizations, and infertility treatments after a voluntary sterilization, except for cases of ectopic pregnancy.
- Charges greater than the usual and customary fee.
- Equipment rental or purchase, such as:
 - Air conditioners
 - Bed: electric and water
 - Cervical pillows
 - Heel lifts
 - Home elevators
 - Filters
 - Grab bars
 - Lift chairs
 - Exercise equipment
 - Massagers
 - Purifiers
 - Saunas
 - Spas
 - Shower seating
 - Swimming pools

- Whirlpools
 - Commodes
- Experimental and Investigative services and supplies.
- Failure to keep a scheduled visit, phone consultations (except as otherwise provided), completion of claim forms and return-to-work or school forms.
- Failure to cooperate with recommended treatment, including checking out of an inpatient facility without treating physician's authorization.
- Services provided by a family member.
- Hypnosis.
- Hospital private room, unless the facility has only private rooms or a private room is medically necessary.
- Hospital weekend admissions
 - Expenses incurred for Friday or Saturday hospital admission, unless due to an emergency, and expenses connected with a Saturday or Sunday discharge, unless medically necessary
- Hospital admissions that are mainly for physical therapy or diagnostic studies.
- Charges incurred before the effective date or after the termination date of coverage, unless otherwise provided.
- LASIK, PRK, and radial keratotomy procedures.
- Massage therapy.
- Medications related to vacation travel.

- Medical or dental department charges of an employer, union or association, except the Cook Family Health Center.
- Services and supplies not medically necessary.
- Occupational therapy materials.
- Personal hygiene and convenience or comfort items (e.g., television and phone).
- Third-party examinations and treatments, such as employment- or insurance-requested exams.
- Travel charges for healthcare.
- Charges that are not listed as a covered charge under the plan.
- Charges for preauthorization or concurrent stay review.
- Premarital tests.
- Prosthetic devices and durable medical equipment that are not medically necessary.
- Routine examinations, immunizations, x-ray services, laboratory services and well-baby and child care, unless otherwise specified.
- Services by an unlicensed provider, or services provided outside the scope of the license.
- Vitamins, non-prescription drugs, prescription drugs primarily for cosmetic purposes, unless Medically Necessary.
- Out-patient prescription drugs (i.e. available through a Retail or Specialty Pharmacy as set out in the Plan Manual)

are excluded from coverage except as provided under the Prescription Drug Benefit.

- Veteran's Administration Hospital charges for a military service-related condition, except for prescription drug charges.
- Vocational training and work hardening programs.
- Private-duty nursing not performed as part of home healthcare services.
- Charges resulting from riot, revolt, or war, declared or undeclared and/or armed aggression or resistance by the military forces of any country or combination of countries or international organization or any act incident to war.
- Charges resulting from commission of a criminal act, including, for example, driving under the influence of alcohol or an illegal substance, or criminal acts involving violence or use of firearms.
- Charges that result from a work-related injury or illness.
- Charges that would not be made in the absence of coverage by this Plan, or that the patient is not legally obligated to pay, or that are paid by a governmental entity, to the extent permitted by law.
- Other services not listed in the Plan Manual or specifically excluded in the Plan Manual.

What Dental Services Are Covered?

Article XII in Plan Manual

Diagnostic and Preventive Services

- Exams, evaluations and consultations and bitewing x-rays.

- Cleanings (prophylaxis).
- Brush biopsy.
- Fluoride treatment under age 19.

Basic and Major Services

- Anesthesia.
- Antibiotic injections.
- Emergency palliative treatment
- Full-mouth x-rays once every 36 months.
- Crowns, inlays, onlays.
- Dentures and partial dentures.
 - Relines and repairs of bridges, implants and dentures once every 36 months if dentures are at least 12 months old.
 - Replacement of existing dentures or fixed bridge if they were placed at least 5 years prior to their replacement, and if the existing dentures or fixed bridge cannot be made serviceable.
- Fillings: amalgam, silicate, acrylic, synthetic porcelain and composite resin.
- Occlusal/night guard per recommendation of dentist; one per lifetime.
- Oral surgery, including pre-operative and post-operative care, except when covered by the medical benefits.
- Periodontal disease treatment.

- Root canals.
- Simple tooth extractions, including pre-operative and post-operative care.
- Space maintainers under age 18.
- Topical sealants under age 14.
- Dental implants.
- Extraction of impacted and semi-impacted teeth.
- Orthodontia services.

What Dental Services Are Not Covered?

Section 12.4 in Plan Manual

This is only a partial list of dental services that are not covered under the plan. For a complete list, see the Dental Certificate of Coverage and the Dental Benefits provisions in the Plan Manual. The plan will not pay for the following:

- Charges that result from a work-related injury or illness, or that are received from any government agency except Medicaid.
- Cosmetic services (for example, teeth whitening), except to repair damage from an injury, provided that services are rendered within two years of the injury, or when services are required to achieve normal body function or to correct a congenital deformity.
- Services and supplies that were provided prior to the effective date of coverage.

- Services that were started before a person became eligible (except for orthodontic treatment) or were provided after the termination of coverage.
- Pre-medications, prescription drugs or general anesthesia for restorative dentistry, unless medically necessary.
- Anesthesiologist services and hospitalization charges, unless medically necessary.
- Charges for failure to keep a scheduled appointment; charges for a phone consultation or to complete claim forms
- Charges for services or supplies that are not medically necessary.
- Treatment performed by any person other than the dentist or dental hygienist.
- Replacement of lost or stolen dentures, or charges for duplicate dentures, bridgework or appliances.
- Charges resulting from riot or war, declared or undeclared.
- Charges for dental injuries resulting from the commission of a criminal act, including, for example, driving under the influence of alcohol or an illegal substance, or criminal acts involving violence or use of firearms.
- Charges for myofunctional therapy or athletic mouth guards.
- Charges for dental services provided by a family member.
- Charges covered under the medical benefits of the plan.
- Charges that are considered experimental or investigative.

- Dietary counseling, oral hygiene and plaque control.
- Transplanting teeth and implanting fabricated teeth, unless otherwise specified by the plan.
- Treatment of temporomandibular joint dysfunction (TMJ), unless medically necessary.
- Sealants, unless otherwise specified.
- Other services not listed in the Plan Manual or specifically excluded in the Plan Manual.

What Vision Services Are Covered?

Article XI in Plan Manual

- Routine eye exams, prescription eyeglasses and prescription contact lenses, as set out in the vision schedule of benefits.
- Services for diseases of the eye are covered, as set out in the medical schedule of benefits.

When Does Coverage End?

Article IV in Plan Manual

Children: At the end of the month in which the child turns 26.

Disabled Children: At the end of the month in which the child turns 26, unless you are actively employed, and covered by the plan, and you establish that your child

- is otherwise eligible,
- is unmarried,
- is incapable of self-sustaining employment because of a mental or physical disability, and

- receives at least 50% support from you, the employee.

Divorce: After divorce, your spouse and stepchildren lose coverage.

Fraud: Coverage can be revoked retroactively if you or a covered person (or someone on behalf of you or a covered person) performs an act, practice or omission that constitutes fraud, or intentionally misrepresents a material fact. Notice will be given to all affected persons 30 days before the retroactive revocation becomes effective. If coverage is revoked retroactively, you may appeal that decision.

Leaves: At the later of: (i) the end of the Stability Period; or (ii) the end of a Family and Medical Leave Act (FMLA) leave or approved non-FMLA leave, such as an extended major medical leave. If you are in the gap period before a decision is made on your request for an unpaid medical leave, or you are on an approved unpaid medical leave, coverage will end when you stop paying your share of the premiums, either through PTO or otherwise.

Nonpayment of premiums

Reduction in hours: If your hours drop below an average of 30 hours per week or a total of 1560 hours during a year, your coverage will end at the end of the Stability Period, which is generally the end of the year.

Termination of Employment: On the date your employment is terminated.

No Longer a Non-Employee Director and Director Emeritus. The date on which the individual ceases to serve on the board as a director of a participating Employer or the date on which the Plan is amended to terminate coverage of non-employee directors or directors emeritus.

Interference of Care by Non-Employee Director and Director Emeritus: The date on which the Plan Administrator determines, in its sole discretion, that the non-employee director or director emeritus continually interferes with the safe and efficient provision of care to the non-employee director or director emeritus or continually behaves in a manner which prevents a physician from providing care to the non-employee director, director emeritus or another covered person.

When Can Coverage Be Extended?

Article V in Plan Manual

- During a Stability Period, so long as you remain employed.
- During an approved FMLA leave.
- During an approved extended major medical leave.
- During an approved non-FMLA leave.
- During a military leave, for up to 24 months.
- During an approved unpaid medical leave so long as you pay the premiums.
- During continuity of care for a Continuing Care Patient
 - If your Provider or facility ceases to be a member of the Network, or the Provider's contract changes in way that affects Plan benefits while you are a Continuing Care Patient, the Plan Administrator or its designee will (i) notify you of the change in the Provider's status, (ii) provide you an opportunity to notify the Plan Administrator or its designee of your need for transitional care, and (iii) allow you to elect to continue to have benefits provided under the Plan under the same terms and conditions as would have

applied, had your Provider's Network status remained unchanged, for a period of up to 90 days, or until you are no longer a Continuing Care Patient, whichever occurs first.

- **Under COBRA, if coverage is lost due to:**

- Death of employee (up to 36 months)
- Divorce or legal separation (up to 36 months)
- Termination of employment (unless for gross misconduct) (up to 18 months)
- Reduction in hours below eligibility requirement (up to 18 months)
- Child “aging out” (up to 36 months)

When Is COBRA Coverage Available?

Section 5.3 in Plan Manual

You must elect COBRA coverage within 60 days of receiving a COBRA notice from the plan, and you must pay your initial premiums for COBRA coverage within 45 days of when you elect COBRA coverage. Your COBRA election form and COBRA premiums must be sent to the address in the COBRA notice. **If you miss one of these deadlines, you will forfeit your right to COBRA coverage.**

You must provide notice to the Cook Insurance Department within 30 days of the birth or adoption of a child, within 60 days of your divorce or legal separation, and within 60 days of your child aging out, or if you or a family member on COBRA is disabled under Social Security during the first 60 days of COBRA coverage, or if Social Security later finds that that person is not disabled. These events will affect who is eligible for COBRA coverage and the length of COBRA coverage. Therefore, it is very important that you give timely notice of

these events.

It is very important that you notify the Cook Insurance Department of any address change.

You can find more information about COBRA coverage in the Plan Manual and the COBRA notices.

Coverage is also available on the Health Insurance Marketplace. The Marketplace can help you evaluate your coverage options. Visit www.HealthCare.gov for more information, including an online application.

How Are Claims Filed?

Article XIII in Plan Manual

Medical Claims

Except for dental claims (see below), the service provider should send claims to the address listed on your Cook Health Plan ID card. Contact the Cook Insurance Department at 800.593.2080 with any questions.

Initial claim submission deadlines

- Should be filed within 90 days after the expense is incurred
- Must be filed within 365 days after the expense is incurred, or the claim is not eligible for payment

Decision on initial claim by Cook Insurance Department

- For urgent care, within 72 hours of receipt of a complete claim
 - or within 24 hours if the claim is to extend preauthorized care

- For pre-service, within 30 days
- For post-service, within 45 days

Appeal submission deadline

- Must file within 180 days after you receive the initial decision

Decision on appeal by Plan Administrator

- For urgent care, within 72 hours
- For pre-service, within 30 days
- For post-service, within 60 days

External Review Deadlines

If a dispute involves (i) a rescission of coverage defined as a cancellation or discontinuance of coverage which has retroactive effect), (ii) a medical judgment (excluding decisions that involve only contractual or legal interpretation without any use of medical judgment), or (iii) an unfavorable or adverse determination involving non-network emergency services, non-network air ambulance, or services provided by a non-network practitioner at a network facility, you may ask the plan to send your claim to an independent review organization for external review. You must request the external review within four months of receiving an adverse appeal decision on your claim.

If your claim is an urgent care claim (because of the nature of your medical condition), you may request an expedited external review following the initial denial or the denial on appeal. The claim will be sent to the independent organization immediately. The organization will provide its decision within 72 hours after it receives the claim.

File Claims and Appeals With:

Cook Group Health Plan Administrator
Cook Group Incorporated
PO Box 1608
Bloomington, IN 47402
812.331.1025

You have a right to review your claim file and present evidence and testimony. If you wish to appeal a denial or request an external review of your claim, you will need to review the Plan Manual's procedures regarding claims, appeals and requests for external review. Ask your HR Department for a copy of the claims section of the Plan Manual for more details. You must bring any legal action with respect to a denied claim within 3 years after the first decision on the claim.

Dental Claims

The dental service provider should send claims to:

Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085

Contact Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or by calling 1-800-524-0149 with any questions.

Initial claim submission deadline

- One year from date services were completed

Decision on initial claim by Delta Dental

- 30 days
 - If additional information is needed and is provided within 45 days of request, decision within 15 days

of receiving information; notice to you within 5 days of decision

Appeal submission deadline

- 180 days after you receive the initial decision
 - Prior to appealing, you may ask Delta Dental to check your claim, if you wish
 - Send appeal to Dental Director, Delta Dental, P.O. Box 30416, Lansing, Michigan 48909-7916.

Decision on appeal by Delta Dental

- Within 60 days

Ask your HR Department for a copy of the claims provisions of the Plan Manual for more details. You must bring any legal action with respect to a denied claim within 3 years after the first decision on the claim.

Vision Claims

The vision service provider should send claims to:

Blue View Vision Claims Administration
PO Box 8504
Mason, OH 45050-7111
Fax - 1.866.293.7373

Vision appeals should be sent to:

Blue View Vision
ATTN: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Tel. — 1.866.723.0515

MISCELLANEOUS MATTERS

Articles XIV and XVI in Plan Manual

Contributions. Cook Group and Covered Persons each are responsible with contributions forward benefits under the Plan. Cook Group, on whose Board the non-Employee director serves, pays the same employer contribution at the same time for the non-Employee director or as it pays for an active Employee. Cook Group will report this contribution amount as taxable income to the non-Employee director. The non-Employee director will pay the active Employee contribution at the same time as active Employees. The contribution paid by the non-Employee director will not, however, be paid with pre-tax dollars.

Amendment/termination. The Advisory Committee of Cook Group, as delegated by the Board of Directors, has the right to amend or terminate this plan at any time.

Coordination of benefits. If a person has benefits under two or more health plans, the Plan Manual includes rules to determine how much each plan pays toward the person's claims.

Interpretation. Cook Group has the authority in its sole discretion to interpret the provisions of this plan, including the eligibility rules and the benefits. Its interpretations are binding on covered persons.

Mistakes and overpayments. If the plan pays more than it owes for medical expenses or pays claims for services that were provided to someone who is not eligible, the plan may recover the overpayments from the provider or the covered person, or from another plan or insurance carrier. The plan also may reduce future payments by the amount it overpaid.

Privacy rules. The plan will comply with all applicable privacy rules. See the Plan Manual for details about these rules.

Subrogation rights. If a person incurs medical expenses, and another person (or insurance company) may be responsible for the person's medical bills (for example, if the injuries result from a car accident), the plan may have a right to receive reimbursement from the other person or insurance company for medical bills it pays. See the Plan Manual for rules.

FREQUENTLY ASKED QUESTIONS

When do the deductibles and annual out-of-pocket maximums start over?

January 1 of each year.

What is preauthorization?

Preauthorization is when you request approval for services such as surgery or a hospital stay before the service is provided. Physicians and hospitals will often contact the preauthorization personnel on your behalf, but in the end it is your responsibility to make sure the preauthorization occurs. Preauthorization is just a determination that services are medically necessary. It is not a guarantee that you are eligible at the time the services are provided or that the services are covered charges.

Preauthorization is sometimes referred to as “precertification” or “prior authorization.”

How do I know if the healthcare service I need requires preauthorization?

Call the preauthorization telephone number on the back of your Cook Group Health Plan ID card or refer to the “Coverage and Claims” section of this booklet.

What happens if a service that requires preauthorization is not approved?

The plan will not pay any benefits for the service, and the charges will not apply toward your out-of-pocket maximum. This does not apply to medically necessary inpatient facility services from a Blue Cross Blue Shield Blue Card network provider.

Can I fax in my medical claim form?

Yes. The fax number for the Cook Insurance Department is 812.330.3213.

How long does it take to process a claim?

It depends on the information submitted to the plan. In general, you should receive an explanation of benefits within 3 to 4 weeks that describes how the claim was paid. If the plan requires additional information to process a claim, it could take a little longer.

How can I search for network providers in my area?

For medical claims, visit www.anthem.com and use the “Find a Doctor” tool to search for medical network providers using the “National PPO (Blue Card PPO)” network or call the “Provider Locator” telephone number on the back of your Cook Health Plan ID card.

For dental claims, visit www.deltadentalin.com.

How can I find out if a physician, hospital or dentist is in the network if I don’t have internet access?

To check if a provider is in the Anthem network, call Anthem at 800.810.2583. For dental network provider information, call Delta Dental at 800.524.0149. For Anthem Blue View Vision network providers call 1.800.723.0515.

What if I am in the Clinic PPO Plan, the Traditional PPO Plan, or High Deductible Health Plan option and there is no medical network providers located in my area?

- If there are no medical network providers located in your area, covered charges from out-of-network providers will be paid at the network level in the following situations:
 - If there is no network primary care physician within 15 miles of your residence
 - If there is no network specialist physician within 45 miles of your residence
 - If there is no network hospital within 30 miles of your residence
 - If you need immediate medical care due to an emergency while you are traveling outside of the network service area, provided you did not travel to that location to receive the medical care
 - If the medical care is necessary due to an emergency
 - If you receive medical care at a network hospital or approved ambulatory surgical center and the facility utilizes the services of an out-of-network lab, radiologist, anesthesiologist, pathologist or emergency room physician then any out-of-network provider services at a network facility will be covered at network rates, and
 - If emergency services are provided in a hospital emergency room or urgent care center for an emergency medical condition.

The Cook Health Plan uses the Blue Cross Blue Shield Blue Card PPO network for members residing in all states except Pennsylvania. If I am traveling outside of my home state or on

vacation and need to see a physician for a non-emergency illness, what should I do?

If you reside outside of Pennsylvania, call the Anthem Provider Locator telephone number on your Cook Health Plan ID card to find Blue Cross Blue Shield Blue Card PPO providers in the area. If there are no Blue Card PPO network providers in the area, go to the nearest immediate-care facility, urgent care facility or hospital emergency room for treatment. Present your Cook Group Health Plan ID card. The Cook Insurance Department will process your claim at the network benefit level.

DEFINITIONS

Words that are not defined in this Booklet here may be defined in the Plan Manual.

The **annual out-of-pocket maximum** is the maximum amount of certain expenses, deductibles, copayments and coinsurance that you have to pay in a calendar year before the plan will pay 100% of those expenses. There is a single-coverage calendar year out-of-pocket maximum and a family-coverage calendar year out-of-pocket maximum.

The **calendar year** begins January 1 and ends December 31 of each year.

A **child** is an employee's natural born child, a child adopted by or placed for adoption with an employee, a step or foster child, or a child for whom the employee has been appointed guardian by court order.

Coinsurance is the percent of the covered charge you are responsible for after you have paid your deductible.

A **continuing care patient** means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from the Provider or facility;
2. is undergoing a course of institutional or inpatient care from the Provider or facility;
3. is scheduled to undergo non-elective surgery from the Provider or facility, including receipt of postoperative care with respect to the surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
5. is determined to be terminally ill (as defined under the Social Security Act) and is receiving treatment for the illness from the Provider or facility.

A **copayment** is the amount you pay for each network office visit.

Covered persons, also known as **covered members**, are eligible employees, spouses and children who enroll in and are covered by the plan.

A **deductible** is the amount of covered charges you must incur and pay each calendar year before the plan will pay for covered charges.

Experimental and investigative drugs, devices, medical treatments or medical procedures are those:

- That cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and for which approval for marketing has not been given, or
- That, based on reliable evidence, are the subject of ongoing phase I, II or III clinical trials, or are under study to determine their maximum tolerated dose, toxicity, safety,

efficacy, or efficacy as compared with the standard means of treatment or diagnosis, or

- For which, based on reliable evidence, the consensus among medical experts is that further studies or clinical trials are necessary to determine their maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Routine patient costs for services furnished in connection with an approved clinical trial are not experimental or investigative.

Medically necessary treatments, services, supplies, equipment and medicines are:

- Appropriate and essential for the diagnosis or treatment of the covered person's symptoms
- Within the scope, duration or intensity of that level of care that is required to provide safe, adequate and appropriate diagnosis or treatment
- In accordance with generally accepted current professional medical practice, and
- Not considered experimental or investigative.

Mental health means a mental, nervous or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the original cause of the disorder, including, but not limited to, transgender therapy and treatments

Serious and complex condition means:

1. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
2. For a chronic illness or condition, a condition that:

- a. is life-threatening, degenerative, potentially disabling, or congenital; and
- b. requires specialized medical care over a prolonged period of time.

A **spouse** is an individual of the same gender or opposite gender of an employee, who is legally married to an employee under the laws of the state (including the District of Columbia), the United States territory or the foreign country where the marriage was performed (regardless of where the couple resides), and is not legally separated from the employee.

The **waiting period** is the first 30 days of continuous employment with a participating employer.

PLAN INFORMATION

Plan Administrator and Named Fiduciary	Cook Group Incorporated P.O. Box 1608 Bloomington, IN 47402 812.331.1025
Cook Group Incorporated Employee Identification Number	35-1084188
Plan Number	501
Coverage Included in Plan	Medical, Prescription Drug, Dental and Vision Benefits
Type of Administration	Medical and vision claims are self-funded and self-administered. Prescription drug claims are self-funded and are administered by TrueScripts Management Services. Dental claims are self-funded and administered by Delta Dental.
Cook Insurance Office	Cook Insurance Department P.O. Box 1029 Bloomington, IN 47402-1029
Agent for Service of Legal Process	Cook Group Incorporated P.O. Box 1608 Bloomington, IN 47402-1608
Funding	The contributions necessary to finance the plan are paid by the participating employers and covered persons and are deposited in a trust.
Financial Records	The financial records of the plan are kept on a calendar year basis, which is also the plan year.

STATEMENT OF ERISA RIGHTS

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge - at the plan administrator's office and at other specified locations, such as worksites - all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description (SPD). The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500. Cook Group, as plan administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

You can continue healthcare coverage for yourself, your spouse, or your children if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse or children may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain free copies of documents relating to the decision, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Cook Group, as plan administrator, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.