SCHEDULE OF BENEFITS – PLAN HDHP

HIGH DEDUCTIBLE HEALTH PLAN

Effective March 1, 2019

This Plan is a High Deductible Health Plan (HDHP), designed to qualify for use with a Health Savings Account (HSA). All charges except charges for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. Benefits are paid subject to the copays, deductibles, benefit percentages and maximum amounts shown below. The plan uses the Blue Cross and Blue Shield of Illinois (BCBSIL) PPO Network. To receive maximum benefits, use Network providers. You may search online at **www.bcbsil.com** to determine if your provider belongs to the BCBSIL PPO Network. If you have questions about your benefits, please contact BVA Customer Service at **1 (855) 686-8517.** BVA representatives are available to help you find quality PPO providers and help you understand your benefits and your share of the costs based on the plan's copays, deductibles, coinsurance, and out of pocket maximums. If you use a Non-Network provider your share of costs will be higher and you may be balance billed by the provider for amounts that exceed the plan's allowed amounts. You will also be responsible for pre-certifying your services when you use Non-Network providers.

Benefit Maximums		
Lifetime Maximum Benefits	Inpatient Mental/Nervous Treatment and Alcohol and Substance Abuse – 120 days Assisted Reproduction Techniques - $20,000	
Calendar Year Maximum Benefits	Outpatient Mental/Nervous Treatment and Alcohol and Substance Abuse – 52 visits Skeletal Adjustment - $750	
Deductible and Out-of-Pocket Maximum	**Network**	**Non-Network**
Calendar Year Deductible* • Individual • Family	 $1,350 $2,700	 $2,700 $5,400
Calendar Year Out-of-Pocket** • Individual • Family	 $4,050 $8,100	 $7,900 $15,800

* If any dependents are covered, the Family Calendar Year Deductible must be satisfied before the Plan will pay expenses for any covered family member, except expenses for preventive care. Each individual in a family is not required to contribute more that the single Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for that individual.

Network and Non-Network deductible and out-of-pocket amounts will accumulate separately.

**** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum**:

- Spinal adjustment charges;
- Charges for surgical procedures for morbid obesity outside the Network;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of the Lifetime or Calendar Year Maximums.

All other Copayments, Coinsurance and Calendar Year Deductibles apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum.

Description of Service	Network	Non-Network
After the Deductible, a Copayment applies for each Inpatient Hospital Admission and Outpatient Surgical Procedure performed at an Outpatient Hospital Facility or Ambulatory Surgical Facility. (maximum of 3 such Copayments per person per calendar year) ***All charges are subject to the Calendar Year Deductible.***		
Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse)	$250 then 80%	$550 then 60%
Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)	$250 then 80%	$550 then 60%
The charges of certain providers will be considered at the same benefit level as the hospital facility in which services are rendered. This benefit applies only to the following inpatient or outpatient hospital facility charges: (1) Inpatient hospital professional fees for radiology, pathology or anesthesiology; (2) Outpatient hospital professional fees for radiology, pathology or anesthesiology.		
Emergency Room Treatment (hospital and emergency room physician fee only). This does not include ambulance transportation.	$300 then 80%	$300 then 80%
Emergency Room Treatment – Out of Network treatment will be subject to the Network Out-of-Pocket Maximum.		
Urgent Care Center/Facility Facility Charge Physician Charge	$40 then 80% 80%	$40 then 80% 80%
Medically Necessary Ambulance Transportation	80%	80%
Medically Necessary Ambulance Transportation – Out of Network Medically Necessary Ambulance Expenses will be subject to the Network Out-of-Pocket Maximum.		
Pre-admission Testing	80%	60%
Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits)	80%	60%
Second Surgical Opinion	80%	60%
Diagnostic Laboratory Expenses (Other than Independent Lab) Diagnostic Laboratory Expenses (Independent Lab)	80% 100%	60% 60%
Diagnostic Laboratory Expenses - When a covered member uses the services of a Network Independent Lab provider, after satisfaction of the calendar year deductible, there will be no out-of-pocket expense to the member and covered services will be covered at 100%.		
Diagnostic X-ray Expenses	80%	60%
Organ and Tissue Transplants	85%	Not Covered
Surgical Treatment of Morbid Obesity	80%	50% up to $50,000
Primary Doctor Office Visit or Retail Clinic Visit (Includes general or family practice, internists, pediatricians and OB/GYN physicians)	$25 then 80%	60%
Specialist Physician Office Visit	$30 then 80%	60%

Description of Service	Network	Non-Network
All charges are subject to the Calendar Year Deductible.		
All services other than the Office Visit during the Primary Doctor or Specialist Office Visit	80%	60%
Skeletal Adjustment	50%	50%
Durable Medical Equipment	80%	60%
Physical, Speech or Occupational Therapy	80%	60%
Home Health Care Home Infusion Skilled Nursing Facility Hospice Care	80%	60%
All Other Covered Expenses	80%	60%

PRESCRIPTION DRUG CARD BENEFIT

Mail Order and Participating Retail Pharmacies

Under an HDHP, most prescription drug charges are subject to the Calendar Year Deductible. For covered drugs classified under IRS guidelines as preventive drugs you will pay the Copayments shown below. However, for drugs prescribed to treat an existing illness or medical condition you must pay 100% of the discounted charge for each prescription until you satisfy the Individual Calendar Year Deductible (if you have individual coverage), or until you and all covered family members satisfy the Family Calendar Year Deductible (if you are enrolled for Employee + Spouse, Employee + Child(ren) or Employee + Family coverage). After you satisfy the applicable Calendar Year Deductible, you will pay the Copayments shown in the following table until your out-of-pocket expenses satisfy the Calendar Year Out-of-Pocket Maximum. The Plan will then pay 100% of the cost of your covered prescription drugs for the remainder of the year. A list of preventive drugs can be found on the Egyptian Trust web site at www.egtrust.org.

The prescription drug program is managed by Prime Therapeutics. You have the option to fill the first two months of a newly prescribed maintenance medication at any Prime network retail pharmacy for the normal 30 day copay. After the first two fills of a maintenance medication each subsequent fill will be required to be a 90 day fill at either a participating 90 day network retail pharmacy or through Home Delivery. You can buy any covered medication that is not a maintenance or specialty medication at any Prime network retail pharmacy. **CVS pharmacies are not in the Prime pharmacy network.**

You are required to purchase specialty drugs that are self-administered through AllianceRx Walgreens Prime Specialty Pharmacy. Specialty drugs are very high cost biologic and injectable drugs that are not typically stocked by retail pharmacies. In most cases specialty drugs are limited to a 30 day supply. **If you try to fill a specialty script at retail after your first fill, the pharmacy will notify you that the drug must be ordered from AllianceRx Walgreens Prime Specialty Pharmacy.** You can contact AllianceRx Walgreens Prime at **1 (877) 627-6337**. Any specialty drug administered in a physician's office, clinical or hospital setting will be covered under the plan's medical benefit.

Prescription Drug Copayments	Retail 30 day supply	Retail 90 day supply Maintenance drugs after first 2 fills	Home Delivery up to 90 day supply
Generic	$12	$36	$30
Preferred Brand	$25	$85	$55
Non-Preferred Brand	$40	$130	$100
Oral & Injectable Specialty Drugs	Copay plus 3%	Copay plus 3%	Copay plus 3%
After you meet the calendar year deductible all specialty drugs (oral and injectable) will have a maximum copay of $150 per month.			

WELLNESS BENEFIT

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRS (the Guidelines), as described under Wellness / Preventive Services in the Covered Major Medical Expenses section of the Plan Document and Summary Plan Description and as outlined on the following page.

Description of Wellness Service	Network	Non-Network
Charges are <u>not</u> subject to the Calendar Year Deductible except as noted. Copayments and Deductibles <u>will</u> apply towards satisfaction of your Calendar Year Out-of-Pocket Maximum.		
Wellness Office Visit for Children (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	60%, after deductible
Wellness Office Visit for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	60%, after deductible
Childhood Immunizations and Vaccinations per Guidelines	100%	100%
Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine	100%	60%, after deductible
Flu vaccine	100%	100% up to $40 maximum
Pneumonia vaccine per Guidelines	100%	100% up to $85 maximum
Zoster (Zostavax) for Shingles per Guidelines	100%	100% up to $200 maximum
Tetanus, Diptheria Toxoids per Guidelines	100%	100% up to $40 maximum
Hepatitis A and B per Guidelines	100%	100% up to $100 maximum
Combined Tetanus, Diptheria and Pertussis (TDAP) per Guidelines	100%	100% up to $55 maximum
Mammogram	100%	100%
Routine Pap Smear	100%	100%
Routine PSA Test	100%	100%
Routine Laboratory, X-ray and Screening Tests recommended by the Guidelines: No dollar limit.	100%	60%, after deductible
Routine Screening for Colorectal Cancer using fecal occult blood testing, Cologuard, sigmoidoscopy or colonoscopy (age 50 and over). Frequency as provided by Guidelines.	100%	60%, after deductible
Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors)	100%	60%, after deductible

Recommended Preventive Services

The following is a **partial list** of services that are covered by the Plan when specifically listed under the Wellness Benefit or when recommended for individuals of the patient's age, gender or health risk factors, in accordance with Guidelines published by the USPSTF, CDC or HRSA. An up-to-date list of the current Guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/

For Children:

- Well child exams
- Standard routine immunizations recommended by the Guidelines
- Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
- Gonorrhea preventive medication for eyes in at risk newborns
- Standard metabolic screening panel for inherited enzyme deficiency diseases
- Screening and counseling for obesity
- Evaluation for fluoride treatment and fluoride supplements
- Behavioral assessments
- Screening for autism (at 18 and 24 months)
- Vision screening
- Oral health assessment
- Developmental screening, autism screening and behavioral assessment
- Screening for lead and tuberculosis

For Women:

- Annual physical exam
- Annual screening mammogram
- Annual pap smears, screening for cervical cancer, HPV testing
- Evaluation, counseling and genetic testing for BRCA breast cancer gene and/or for chemoprevention for women at high risk for breast cancer due to family history or other factors
- Screening pregnant women for anemia, gestational diabetes, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
- Screening for gonorrhea, chlamydia, syphilis
- Counseling and equipment to promote and aid with breast feeding
- Folic acid supplements for pregnant women
- Screening for domestic and interpersonal violence
- Osteoporosis screening (age 60 or older)
- FDA approved contraceptive methods, sterilization procedures and counseling

A detailed listing of women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

For Men:

- Annual physical exam
- Annual PSA test/screening for prostate cancer
- Screening for abdominal aortic aneurysm (ages 65 – 75 with history of smoking)

For Adolescents and Adults at Appropriate Ages or With Risk Factors:

- Screening for elevated cholesterol and lipids, high blood pressure, diabetes
- Screening and counseling for certain sexually transmitted diseases and HIV
- Screening and counseling for hepatitis B and C
- Screening and counseling for alcohol abuse in a primary care setting
- Screening, counseling and interventions for tobacco use
- Screening and counseling for obesity, diet and nutrition
- Screening for depression in a primary care setting
- Screening for colorectal cancer (ages 50 – 75)
- Screening for lung cancer (ages 55 – 80 with history of smoking)
- Standard routine immunizations recommended by the Guidelines
- Aspirin to prevent cardiovascular disease (women ages 55 – 79; men ages 45 – 79)

In some cases the Guidelines specify how often the Plan must cover a service as a recommended preventive service when provided by a Network provider. In other cases, the Plan may impose reasonable frequency limits or may use reasonable medical management techniques to ensure that care is provided in an appropriate setting.