

**SCHEDULE OF BENEFITS – PLAN H4**

**Effective September 1, 2021**

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](http://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 **(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.

| <b>Benefit Maximums</b>   |  |  |
|---|--|--|
| Lifetime Maximum Benefits   | Assisted Reproduction Techniques - \$20,000                                |  |
| Calendar Year Maximum Benefits  | Chiropractic and Osteopathic Manipulation - \$750                          |  |
| <b>Deductible and Out-of-Pocket Maximum</b>   | <b>Network</b>   | <b>Non-Network</b>   |
| Calendar Year Deductible*   |  |  |
| <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>  | <ul style="list-style-type: none"> <li>\$3,600</li> <li>\$7,200</li> </ul> | <ul style="list-style-type: none"> <li>\$7,200</li> <li>\$14,400</li> </ul>  |
| Calendar Year Out-of-Pocket**   |  |  |
| <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>  | <ul style="list-style-type: none"> <li>\$3,600</li> <li>\$7,200</li> </ul> | <ul style="list-style-type: none"> <li>\$10,800</li> <li>\$21,600</li> </ul> |
| * Each individual in a family is not required to contribute more than the single Deductible/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.  |  |  |
| <b>** The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum:</b> <ul style="list-style-type: none"> <li>• Spinal adjustment (chiropractic and osteopathic manipulation) charges;</li> <li>• Charges for surgical procedures for morbid obesity outside the Network;</li> <li>• Penalties for failure to pre-certify when required by the Plan;</li> <li>• Any ineligible expenses;</li> <li>• Any expenses in excess of the Lifetime or Calendar Year Maximums.</li> </ul> |  |  |

| Description of Service   | Network | Non-Network        |
|--|---------|--------------------|
| <b>All charges are subject to the Calendar Year Deductible unless otherwise noted.</b>   |         |                    |
| Inpatient Hospital Services for treatment of illness or injury (including Mental/Nervous, Alcohol and/or Substance Abuse)  | 100%    | 70%                |
| Outpatient Surgery at a Hospital or Ambulatory Surgical Facility (except Emergency Room treatment)   | 100%    | 70%                |
| <p>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:</p> <p>(1) Inpatient hospital professional fees for radiology, pathology or anesthesiology;<br/> (2) Outpatient hospital professional fees for radiology, pathology or anesthesiology.</p> |         |                    |
| Emergency Room Treatment (hospital and emergency room physician fee only).   | 100%    | 100%               |
| Urgent Care Center/Facility or Physician   | 100%    | 70%                |
| Medically Necessary Ambulance Transportation   | 100%    | 100%               |
| Pre-admission Testing  | 100%    | 70%                |
| Physician's Inpatient Visits (includes Medical, Surgical, Mental/Nervous, Alcohol and/or Substance Abuse visits)   | 100%    | 70%                |
| Second Surgical Opinion  | 100%    | 70%                |
| Diagnostic Laboratory Expenses (Independent Labs)  | 100%    | 70%                |
| Diagnostic Mammogram   | 100%    | 70%                |
| Diagnostic X-ray Expenses  | 100%    | 70%                |
| Organ and Tissue Transplants   | 100%    | Not Covered        |
| Surgical Treatment of Morbid Obesity   | 100%    | 50% up to \$50,000 |
| Primary Doctor Office Visit or Retail Clinic Visit (Includes general or family practice, internists, pediatricians, OB/GYN physicians and mental health providers)   | 100%    | 70%                |
| Specialist Physician Office Visit  | 100%    | 70%                |
| All services other than the Office Visit during the Primary Doctor or Specialist Office Visit  | 100%    | 70%                |
| Physician's Outpatient Mental/Nervous, Alcohol and/or Substance Abuse Visits   | 100%    | 70%                |
| Chiropractic and Osteopathic Manipulation  | 100%    | 70%                |
| Durable Medical Equipment  | 100%    | 70%                |
| Hearing Aids or Devices and related services <ul style="list-style-type: none"> <li>- Children up to age 18 (limited to one hearing instrument for each ear every 36 months)</li> <li>- Age 18 and older participants (limited to \$2,500 per instrument for each ear every 24 months)</li> </ul>  | 100%    | 70%                |

| Description of Service  | Network | Non-Network |
|---|---------|-------------|
| Physical, Speech or Occupational Therapy                                      | 100%    | 70%         |
| Home Health Care<br>Home Infusion<br>Skilled Nursing Facility<br>Hospice Care | 100%    | 70%         |
| All Other Covered Expenses  | 100%    | 70%         |

### **PRESCRIPTION DRUG CARD BENEFIT**

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 an Extended Supply Network (ESN) 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 the network 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 Accredo Specialty Pharmacy.** You can contact Accredo at **1 (833) 721-1619**. Any specialty drug administered in a physician's office, clinical or hospital setting will be covered under the plan's medical benefit.

| Prescription Drug Coverage   | Participating Pharmacy | Non-Participating Pharmacy (Non-Network) |
|--|------------------------|--|
| <b>All charges are subject to the Calendar Year Deductible unless otherwise noted.</b> |                        |  |
| <b>Generic</b>   | 100%                   | 70%                                      |
| <b>Preferred Brand</b>   | 100%                   | 70%                                      |
| <b>Non-Preferred</b>   | 100%                   | 70%                                      |
| <b>Oral &amp; Injectable Specialty Drugs*</b>  | 100%                   | n/a                                      |
| <b>Preventive Drugs (Prescription Drugs classified as a Preventive Drug by HHS)**</b>  | 100%<br>no deductible  | 70%                                      |

\*First **specialty** fill may be at retail (if available), thereafter you MUST use the network Specialty Pharmacy.

\*\***Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

**WELLNESS BENEFIT**

The Plan covers certain routine health care services and recommended preventive services based on guidelines published by the USPSTF, CDC, and HRSA (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              |
|---|---------|--------------------------|
| <b><i>Charges are <u>not</u> subject to the Calendar Year Deductible except as noted.</i></b>   |         |                          |
| Wellness Office Visits for Children (when recommended by Guidelines based on patient's age, gender or health risk factors)  | 100%    | 70%, after deductible    |
| Wellness Office Visits for Adolescents and Adults (when recommended by Guidelines based on patient's age, gender or health risk factors)                                  | 100%    | 70%, after deductible    |
| Childhood Immunizations and Vaccinations per Guidelines   | 100%    | 70%, after deductible    |
| Adult Immunizations and Vaccinations per Guidelines; Includes HPV vaccine   | 100%    | 70%, 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  |
| Routine Mammogram   | 100%    | 100%                     |
| Routine Pap Smear   | 100%    | 100%                     |
| Routine PSA Test  | 100%    | 100%                     |
| Routine Laboratory, X-ray and Screening Tests recommended by Guidelines.  | 100%    | 70%, 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%    | 70%, after deductible    |
| Other recommended preventive services (when recommended by Guidelines based on patient's age, gender or health risk factors)  | 100%    | 70%, 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.