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If you are an eligible associate, the Advocate Centered Health Maintenance Organization (HMO) coverage option offers important protection against the high cost of medical care for you and your covered family members, as described in this summary booklet.

This coverage option:
• Pays 90% of the cost (through coinsurance) for certain services—inpatient hospital, outpatient surgery and outpatient diagnostic imaging tests (such as MRIs, CAT scans and PET scans) and you pay 10% of the cost of these services
• Pays 100% of the cost of office visits after you pay a copayment,
• Pays 100% of the cost of covered coinsurance services once you reach the annual out-of-pocket expense limit, and
• Limits your out-of-pocket coinsurance expenses each year to not more than:
  – $3,750—if you elect single coverage,
  – $5,625—if you elect associate + child(ren)
  – $7,500—if you elect associate + spouse/partner
  – $9,375—if you elect family.

**Important!** If you choose the Advocate Centered HMO, you MUST choose a Primary Care Physician (PCP) who is a member of the Advocate Centered HMO Network. Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.

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This is a summary of the benefits available through the Advocate Centered HMO Medical Plan which is a medical coverage option under the Advocate Health Care Network Welfare Benefits Plan (the “Plan”). While every effort has been made to accurately describe the Plan and the Advocate Centered HMO Medical Plan option, this booklet—as a summary—does not cover all the details of the Plan (or its underlying medical plan options) or how the rules will apply to every person, in every situation. The complete rules that govern the Plan (and the underlying medical plan options) are contained in the official Plan document. In the event of a discrepancy between the information contained in this summary and the official Plan document, the Plan document will always govern.

Advocate intends to continue the Plan, but reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time for any reason. In the event of a change, the Plan document will always govern. If the Plan is terminated, your coverage will end; however, you will be entitled to Plan benefits for any covered services incurred before the date the Plan was terminated.

This booklet is not a contract of employment and nothing in the Plan gives any associate the right to be retained in the service of Advocate Health Care Network (“Advocate”) or any of its affiliated companies.
At Advocate, we know the value of good health and we understand what it takes to be healthy. After all, it’s our business.

For all of us at Advocate, good health is a common goal and a shared commitment, not only for our patients, but for our associates and their families. While it’s up to you to take care of yourself and your family, Advocate is committed to helping you keep well. That’s why Advocate’s medical plan options:

- Offer valuable features designed to encourage you to take advantage of preventive care services that can detect conditions that can benefit from early treatment (before they become more serious or potentially life threatening), and
- Provide valuable benefits to help pay the cost of the care that’s needed to treat—and cure—health conditions that do arise.

It’s also why Advocate sponsors Health e You—a special benefit program that complements your coverage under an Advocate medical plan option—to promote wellness and support healthy lifestyle choices.

**Health e You: Building a Culture of Health and Wellness**

As a leader in health care, Advocate is committed to building and sustaining a culture of health and wellness among our associates.

Advocate’s medical plan options:

- Offer valuable features to encourage you to take advantage of preventive care services that can detect conditions before they become more serious or life threatening;
- Provide valuable benefits to help pay the cost of care to treat and cure health conditions;
- Offer associates and their covered spouses/partners a free, voluntary health and wellness program called Health e You to help them manage, maintain and improve their health.

**Better health, better life, big rewards**

Health e You is an award-winning health and wellness initiative that includes resources, support and financial incentives. This comprehensive program includes:

- Online Health Risk Questionnaire
- Biometric and tobacco health screenings
- Personal telephonic lifestyle health coaching
- Tobacco cessation resources
- Indoor and outdoor walking paths
- Special events and challenges
- Ambassadors and committees at Advocate sites who volunteer to plan and support special events and wellness programs
- One-on-one support for chronic and complex medical conditions
- Online health programs and courses
- Discounts for fitness centers, equipment and weight management programs
- Healthy options in vending machines and cafeterias
- Recognition of Health e Champions—participants with health and wellness successes

Health e You is designed to provide equal access to all associates at Advocate Health Care sites who are participating in medical benefits. Many of the personalized tools and resources are available in electronic form, hence the “e” in Health e You. These online resources allow Health e You to reach associates located at more than 250 sites of care.
Health Rewards: It Pays to Take Charge of Your Health

Health Rewards are integrated into Advocate’s medical plans and reinforce core principles of prevention and wellness as well as financial planning. Associates covered by medical benefits and their covered spouse/partner must actively participate in Health Rewards programs and complete required health-related activities to earn these financial incentives known as Health Rewards.

Health Rewards recognize participants’ efforts to take charge of their health. Two primary financial incentives are offered:

| Health Rewards Credit | By completing the Health Measures program, participants can earn a $600 (EPO or PPO) or $200 (HMO) Health Rewards Credit. The Health Rewards Credit is placed in the Deductible Reimbursement Account (EPO or PPO participants) or a Copay/Coinsurance Reimbursement Account (HMO participants).
|                       | Participants can use their Health Rewards Credit to reimburse eligible medical expenses throughout the year as they are incurred. Any funds remaining in their account roll over each year into a Health Futures Account that can be used to pay for eligible medical expenses during retirement. |

| Health Rewards Points | By participating in Health You programs and events, associates and their covered spouse/partner can earn Health Rewards Points. The more Health Rewards Points earned the more entries participants receive in quarterly $500 cash raffles and a $5,000 Annual Health Rewards Grand Prize Raffle. |

Health Measures: Supporting Behavior Change and Healthy Lifestyles

Health Measures is a voluntary health screening and behavior change program that provides participants with information about potential health concerns and offers support to help them manage and improve their health. Participants must complete set steps within the program’s established deadlines to earn their Health Rewards Credit.

Protecting confidentiality and privacy is a top priority of the Health You program. Personal health information created or used by Health You is handled in accordance with privacy standards established by the Health Insurance Portability and Accountability Act (HIPAA).

More information about Health You is available at: advocatebenefits.com > Benefits Information > Health You.
This section highlights some key features and selected covered services of the Advocate Centered HMO coverage option. For more detailed descriptions, see *HMO Benefits*, pages 13–23.

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<th>Feature</th>
<th>How Advocate Centered HMO Works¹</th>
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<tr>
<td>When Coverage Begins</td>
<td>If you are eligible, coverage for you and your eligible dependents can begin on the day after you complete 30 days of employment with Advocate or one of its affiliated companies.</td>
</tr>
<tr>
<td>Cost of Coverage</td>
<td>You and Advocate share the cost of coverage. Your contributions—which are based on your length of service as an Advocate associate and, if you are a full-time associate, your annual pay—are deducted from your pay on a pre-tax basis.</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>You must choose a PCP from a list of participating physicians who are members of the Advocate Centered HMO Network. Your PCP will be responsible for coordinating your care under the Plan; no benefits will be paid for any services provided without your PCP’s authorization—except in an emergency.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Plan pays 100% of covered charges—with no coinsurance or copayments—when preventive care services are received from your PCP.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You will pay a percentage of certain covered services for which the Plan pays 90%, you pay 10%.</td>
</tr>
<tr>
<td>Copayments</td>
<td>You will pay a specified flat-dollar amount for certain covered health care services at the time care is received. Once you pay the copayment, the Plan will pay the full balance of the remaining cost of the covered health care service.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Expense Limits</td>
<td>Once the amount you pay in coinsurance reaches the annual out-of-pocket expense limit—$3,750 if you have single coverage, $5,625 if you have associate + child(ren), $7,500 if you have associate + spouse/partner coverage, $9,375 if you have family coverage—the Plan will pay 100% of covered expenses for the balance of the year.</td>
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¹ Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
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<th>Type of Service</th>
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<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
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<td>• Inpatient Hospital Stays</td>
<td>Plan pays 90% coinsurance; you pay 10%</td>
</tr>
<tr>
<td>• Out-Patient Surgery</td>
<td>Plan pays 90% coinsurance; you pay 10%</td>
</tr>
<tr>
<td>• Out-Patient Advanced Imaging (PET, CAT, MRI)</td>
<td>Plan pays 90% coinsurance; you pay 10%</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
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<tr>
<td>• Services Provided in ER at Participating Hospital</td>
<td>$200 copayment per visit—copayment waived if admitted</td>
</tr>
<tr>
<td>• Services Provided in ER of Non-participating Hospital</td>
<td>Plan pays 90% coinsurance, you pay 10%</td>
</tr>
<tr>
<td></td>
<td>If for emergency services, treated same as services provided by ER of participating hospital</td>
</tr>
<tr>
<td><strong>Basic Physician Services (provided by PCP)</strong></td>
<td></td>
</tr>
<tr>
<td>• Physician’s Office Visits</td>
<td>$35 copayment per visit</td>
</tr>
<tr>
<td>• Physician’s Inpatient Hospital Visits</td>
<td>No charge</td>
</tr>
<tr>
<td>• Injections of drugs and medicines</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Routine Diagnostic Lab tests and X-rays</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Surgery, Anesthesia and Its Administration</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Diagnostic and Referral Services for Mental and Nervous Disorder, Alcoholism or Drug Abuse</td>
<td>$35 copayment per visit</td>
</tr>
<tr>
<td>• Immunizations—Well Child</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Office Visits for Pediatric Well-Baby Care</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Office Visits for Annual Physical Exam</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td><strong>Basic Physician Services (provided by specialist with PCP’s approval)</strong></td>
<td></td>
</tr>
<tr>
<td>• Physician’s Office Visits</td>
<td>$50 copayment per visit</td>
</tr>
<tr>
<td>• Physician’s Inpatient Hospital Visits</td>
<td>No charge</td>
</tr>
<tr>
<td>• Injections of Drugs and Medicines</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Routine Diagnostic Procedures, Tests or X-ray Exams</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Surgery, Anesthesia and Its Administration</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td>• Second Surgical Opinions</td>
<td>No charge (after each physician’s office copayment)</td>
</tr>
<tr>
<td><strong>Other Medical and Physician Services</strong></td>
<td>Plan pays 90% coinsurance, you pay 10%</td>
</tr>
<tr>
<td>• Home Health Care Services</td>
<td>Plan pays 90% coinsurance, you pay 10%</td>
</tr>
<tr>
<td>• Skilled Nursing Facility Services</td>
<td>$50 copayment per visit up to maximum of 20 spinal manipulations and therapy</td>
</tr>
<tr>
<td>• Chiropractic Care</td>
<td>$35 copayment</td>
</tr>
<tr>
<td>• X-rays</td>
<td>$35 copayment per visit; up to 60 visits per calendar year</td>
</tr>
<tr>
<td>• Physician, Occupational and Speech Therapy</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>Subject to same coinsurance/copayments that apply to other services provided for illness</td>
</tr>
<tr>
<td><strong>TMJ Syndrome, Dysfunction Services Disorder and CMJ Disorder</strong></td>
<td>Subject to same coinsurance/copayments that apply to other services provided for treatment of illness; does not include services and supplies which are recognized as dental procedures or appliances</td>
</tr>
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¹ Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Benefits1</th>
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<tr>
<td><strong>Behavioral Health Care Services</strong>2</td>
<td></td>
</tr>
<tr>
<td>• Mental and Nervous Disorders</td>
<td>• Same as other services</td>
</tr>
<tr>
<td>– Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>– Outpatient Care</td>
<td></td>
</tr>
<tr>
<td>• Alcoholism and Drug Dependency</td>
<td>• Same as other services</td>
</tr>
<tr>
<td>– Detoxification Services</td>
<td></td>
</tr>
<tr>
<td>– Inpatient Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>– Outpatient Rehabilitation Visits</td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplant Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Room, Board and General Nursing Care</td>
<td>• 10% coinsurance</td>
</tr>
<tr>
<td>• Physician Services</td>
<td>• Covered same as for care and treatment of any other covered illness or injury</td>
</tr>
<tr>
<td>• Organ Acquisition and Donor Costs</td>
<td>• No benefits paid if costs are payable by any other group insurance plan, insurance company, organization or person other than donor’s family or estate</td>
</tr>
<tr>
<td>• Direct, Non-Medical Costs</td>
<td></td>
</tr>
<tr>
<td>– For patient</td>
<td></td>
</tr>
<tr>
<td>– For family members</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Plan pays 90% coinsurance; you pay 10%</td>
</tr>
<tr>
<td><strong>Prescription Drugs Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>• At a Retail Pharmacy—30 day supply</td>
<td></td>
</tr>
<tr>
<td>• Via Mail Order—90 day supply</td>
<td></td>
</tr>
<tr>
<td>• Generic Oral Contraceptives $0 Copay</td>
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### Copayments:

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<tr>
<th></th>
<th>Value Generic</th>
<th>Tier 1 Generic</th>
<th>Tier 2 PDL1</th>
<th>Tier 3 Non-PDL</th>
<th>Specialty</th>
<th>Diabetic Supplies</th>
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</thead>
<tbody>
<tr>
<td>Retail (30-day supply)</td>
<td>$3.33</td>
<td>$15</td>
<td>$45</td>
<td>$75</td>
<td>NA</td>
<td>$45</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
<td>$9.99</td>
<td>$35</td>
<td>$100</td>
<td>$160</td>
<td>$75²</td>
<td>$100</td>
</tr>
</tbody>
</table>

1. Performance Drug List
2. Specialty medication is available ONLY from OptumRx Specialty Pharmacy in 30-day increments.

1 Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
2 Must be pre-certified; call 800.454.6455.
* Performance Drug List
Eligibility
To be eligible to participate in the Plan, you must be employed by Advocate or one of its affiliated companies that participates in the Plan (an “Advocate Company”) as a:
• Full-time associate—who works at least 40 hours per work week (or who works 36 hours per week and is classified as an “E9” or “N9” associate),
• Part-time A associate—who works at least 32 (but less than 40) hours per work week, or
• Part-time B associate—who works at least 20 (but less than 32) hours per work week.
You must also have completed 30 days of employment with Advocate or one of its affiliated companies to be eligible to participate. Satisfying these requirements means that you are a “benefits-eligible” associate or in a “benefits-eligible” position or status as referred to throughout this summary.

You can purchase medical coverage for eligible family members, including:
• Your lawful spouse,
• Your civil union or domestic partner
  Note: For more information about the eligibility of a civil union or domestic partner for coverage under the Plan, refer to the Partner Benefits Information Guide online at advocatebenefits.com (go to Benefits Information > Partner Benefits).
• Your children up to age 26. Note: Children include your:
  – Natural children,
  – Stepchildren,
  – Adopted children (including children placed with you for adoption),
  – Foster children, and
  – Any children for whom you have legal guardianship.

Note: You cannot be covered under any of the Advocate medical plan options as both an associate and a dependent. If both parents are benefits-eligible associates, only one parent can cover the children as dependents. You or your dependents may not elect to be covered under more than one Advocate medical plan option.

Enrollment
To enroll initially or to change your existing coverage after a transfer to benefits-eligible status, you must log on to advocatebenefits.com. You will receive a system-generated Benefits Enrollment Guide, which will specify your designated enrollment period.

Advocate reserves the right to periodically audit the eligibility process and request documentation from Plan participants to verify eligibility for the Plan or the payment of benefits under the Plan. Associates found to be involved in acts of dishonesty are subject to disciplinary action, up to and including termination of employment.

Important! You should review your enrollment materials carefully to ensure you are aware of your designated enrollment period. If you do not enroll during your designated enrollment period, you will not be able to enroll for coverage until the next annual enrollment period—unless you have a qualified work, family or eligible life status change (see Work, Family or Eligible Life Status Change, page 12).
Incapacitated Dependents
A child will remain eligible for coverage under the Plan beyond the date coverage would otherwise be lost if the child is:
• Unmarried,
• Mentally or physically incapacitated, and
• Dependent upon you for support and maintenance).

Advocate will request proof of the child’s incapacity after he or she reaches the Plan’s eligibility age limit. This proof must be provided within 45 days of the child’s loss of eligibility. In addition, Advocate may have the dependent examined by a physician to verify the incapacity.

Cost
You and Advocate share the cost of the medical coverage you choose. Your cost for this coverage will automatically be deducted from your pay each pay period on a pre-tax basis. This means that your cost for coverage is not subject to federal, state and Social Security taxes because the cost is deducted from your pay before income and Social Security taxes are calculated. This reduces your taxable income and, in turn, the taxes you pay. The resulting tax savings reduces your out-of-pocket cost for coverage.

The amount you pay toward the cost of your Advocate medical coverage each pay period will depend on four things:
• Your associate classification,
• The level of coverage you choose—Single, Associate + Child(ren), Associate + Spouse/Partner, or Family,
• Your years of benefits-eligible service, and
• Your annual pay (if you are a full-time associate).

For more information, see the appropriate Associate Contributions rate sheet available at advocatebenefits.com (go to Benefits Information > Medical Benefits > Associate Contributions).

If you enroll a domestic partner or civil union partner under your coverage, your contributions for the cost of coverage for you and your other eligible dependents are taken on a pre-tax basis, but—in accordance with federal tax laws—your contributions for the coverage of your domestic partner or civil union partner are taken from your pay on an after-tax basis, and you will have an additional amount added to your taxable income that is equal to the amount Advocate pays for your domestic partner’s or civil union partner’s coverage. For additional information, please review the Partner Information Guide.

How do I access information about my Advocate Benefits?
You can access benefits information online at advocatebenefits.com from your worksite through an Advocate-networked personal computer or kiosk or by calling the Advocate Benefits Service Center at 800.775.4784.
When Coverage Begins

Coverage for You
Your coverage under the Plan can begin on the day after you complete 30 days of employment with Advocate or one of its affiliated companies and are in a benefits-eligible position with an Advocate Company—as long as you enroll for coverage during your designated enrollment period. If you do not elect coverage within that period, you will receive a notice confirming your non-election of coverage. If you subsequently want to enroll for coverage and do so within 60 days of your hire date or, if later, the date you transfer into a benefits-eligible position—your coverage will begin retroactive to your original eligibility date.

If you do not enroll within 60 days of your hire or the date you transfer into a benefits-eligible status, you will have to wait until the next annual enrollment period to enroll or until you have a qualified work, family or eligible life status change (see Work, Family or Eligible Life Status Change, page 12).

Once your coverage under the HMO begins, it will continue for the balance of the current calendar year as long as you remain eligible and continue to pay the contributions required for this coverage.

Coverage for Your Eligible Family Members
Coverage for your eligible family members will begin on the same date as your coverage or, if later, the date they become eligible for coverage, provided you enroll them. If you do not enroll your eligible family members for coverage within 30 days after they first become eligible, you will not be able to enroll your eligible family members for coverage until the next annual enrollment period or you have a qualified work, family or eligible life status change (see Work, Family or Eligible Life Status Change, page 12).

Once a family member’s coverage begins, it will continue for the balance of the current calendar year as long as your family member remains eligible and you continue to pay the contributions required for this coverage.

How do I enroll for coverage?
Once you are eligible, you will receive an enrollment workbook that provides you with a Personal Identification Number (PIN). To enroll initially, you must go online at advocatebenefits.com or call the Advocate Benefits Service Center at 800.775.4784.

Making Changes
You may change your medical coverage election during any annual enrollment period. Changes made during an annual enrollment period take effect on the next January 1.

You also may change your medical coverage election when a qualified work, family or eligible life status change occurs (see Work, Family or Eligible Life Status Change, page 12).
This type of coverage election change—which must be consistent with the status change—must be made online at advocatebenefits.com or by calling the Advocate Benefits Service Center at 800.775.4784 within 90 days of the date the status change occurs. If you request the change:

- **Within the first 30 days**—the change will take effect retroactive to the date the qualified work, family or eligible life status change occurred.
- **Within the 31st to 90th days**—coverage will begin on the date your request is received by the Advocate Benefits Service Center. To change your coverage election more than 30 days after the qualifying event, you must call the Advocate Benefits Service Center.

However, coverage for a newborn child, a newly adopted child or a child who is placed with you for adoption will take effect on the date of the birth, adoption or placement for adoption—as long as you request the change within 90 days of that date.

**Note:** In the event of a qualified work, family or eligible life status change that relates to your employment with an Advocate Company (e.g., your associate classification changes from Part-Time A to Full-Time), you will be sent—automatically—a packet providing information and instructions regarding your coverage change opportunity.

You may be able to enroll yourself and/or your eligible family members for HMO coverage during the plan year, even if you had chosen to waive coverage during annual enrollment because you had other medical coverage if you lose that other coverage during the year. To take advantage of this special enrollment opportunity, you and your eligible family members:

- **Must** have been covered under another group health care plan or health insurance coverage at the time you were eligible for coverage under the Plan, and
- **Must** lose the other coverage because continuation coverage ended, you or your dependents are no longer eligible under that coverage, you lose coverage as the result of a spouse’s (or domestic partner’s or civil union partner’s) loss of employment, or the other employer stops paying contributions for coverage.

This type of special enrollment must be made online at advocatebenefits.com or by calling the Advocate Benefits Service Center at 800.775.4784 within 90 days of the date you or your eligible family members lose coverage. If you enroll:

- **Within the first 30 days**—coverage will begin retroactive to the date you or your dependents lost coverage.
- **Within the 31st to 90th days**—coverage will begin on the date you complete this special enrollment.

Generally, if you do not request a coverage change within 90 days of a status change, you will have to wait until the next annual enrollment period to change your coverage. Changes in coverage to drop a family member as a result of a divorce or losing their eligible status may be made retrospectively at any time, but you will not be refunded any premiums paid to cover such individuals during any period of non-coverage unless you request the coverage change within 30 days of the date of the status change.

You will need to provide copies of supporting documents for certain types of qualified work, family or eligible life status changes or special enrollment events (for example, if you get married, you will need to provide a copy of your marriage certificate). You will be notified if documentation supporting your coverage election change or special enrollment is required. If you do not provide the required documentation within 45 days of the date you request a coverage
election change or complete a special enrollment, your coverage elections will go back to what they were before you requested the change or completed the special enrollment, and you will not be able to make a change until the next annual enrollment period (unless you have another qualified work, family or eligible life status change). You will be responsible for any premiums for non-covered individuals.

Additional information about qualified work, family or eligible life status changes is available online at advocatebenefits.com (go to Advocate Benefits Online Status Change) or by calling the Advocate Benefits Service Center at 800.775.4784.

Work, Family or Eligible Life Status Changes
You have a qualified work, family or eligible life status change if:

- You marry or you meet the criteria to add a domestic partner or civil union partner (see definition in the Partner Information Guide)
- You have a newborn, you adopt a child (under age 26) or a child (under age 26) is placed with you for adoption
- You have a court order requiring coverage of a child (under age 26) under an Advocate health plan
- You divorce or legally separate from your spouse, have your marriage annulled or end a domestic partnership or civil union partnership
- Your child becomes eligible or is no longer eligible for coverage
- You or your dependents lose coverage under another employer’s plan
- You, your spouse’s (or domestic partner’s or civil union partner’s) or child’s employment status changes and loses eligibility for his or her group coverage
- You, your spouse (or domestic partner or civil union partner) or child start or change employment status and become eligible for coverage under the Plan
- Your spouse (or domestic partner or civil union partner) or child dies
- You or a dependent loses coverage under Medicaid or SCHIP, or becomes eligible for a state premium assistance subsidy from Medicaid or SCHIP1
- You, your spouse (or domestic partner or civil union partner) or child becomes entitled to or loses eligibility for Medicare
- You or your spouse’s (or domestic partner’s or civil union partner’s) benefit coverage or cost of coverage under the Plan changes significantly
- You or your spouse (or domestic partner or civil union partner) go on an unpaid leave of absence, or
- You, your spouse (or domestic partner or civil union partner) or your child change place of residence that results in a gain or loss of eligibility for coverage.

1 You may request coverage due to this status change within 60 days after the event.

Rehire Policy
If you terminate employment with an Advocate Company or reduce your hours of work to a non-benefits eligible status and then at least 30 days later become benefits-eligible or return to work with an Advocate Company, you will be treated as a new hire for purposes of participation in the Plan. There will be a 30-day waiting period before benefits can become effective, and you must call the Advocate Benefits Service Center at 800.775.4784 in order to elect medical coverage under this HMO option or any other medical plan option. If you are rehired or become benefits-eligible in less than 30 days after your termination of employment or loss of benefits-eligible status, you will be re-enrolled in the HMO coverage option as was in place immediately before your termination of employment or loss of benefits-eligible status.

If you are rehired by an Advocate Company within 12 months of your termination of employment with and while receiving severance benefits from an Advocate Company, your participation in the Plan will be reinstated with the same benefit elections as those in effect immediately prior to your termination of employment.
HMO Benefits

Under this HMO medical coverage option, benefits generally will be paid only for health care services that you and your covered dependents receive from—or based on a referral or recommendation from—your PCP. The Plan will pay benefits for covered services provided without your PCP’s involvement, however, if those services are provided in the event of an emergency, as defined by the Plan and applicable law (see Emergency Coverage at Non-participating Providers, page 20).

Choosing a Primary Care Physician (PCP)
To receive benefits under the HMO, you and your covered dependents must each choose a PCP who is a member of the Advocate Centered HMO Network. You have the right to designate any PCP who participates in the Advocate Centered HMO Network and who is available to accept you or your family members. For children, you may designate a pediatrician in the Advocate Centered HMO Network as their PCP. Your PCP will be responsible for providing, prescribing, directing and authorizing all your care and treatment.

You and each of your covered dependents can choose a different PCP from the Advocate Centered HMO Network provider directory. If you don’t choose a PCP when you enroll in the HMO, a PCP will be assigned to you automatically.

You and your covered dependents can change your PCP selection as long as the physician you want to select as your new PCP is accepting new patients. The change generally will take effect within a few weeks of when you submit your PCP change with Humana (by calling 866.636.2371).

For information on how to select a PCP, and for a list of the participating PCPs in the Advocate Centered HMO Network, contact Humana (by calling 866.636.2371).

Coverage Amounts

Coinsurance
The HMO pays 90% of the cost for certain services and you pay 10% of the cost of these services. Medical services to which this coinsurance feature applies are:

• Inpatient hospital care
• Outpatient surgery
• Outpatient diagnostic imaging tests—such as MRIs, CAT scans and PET scans, and
• Outpatient observation.

When the coinsurance that you and your covered dependents pay during a calendar year reach a specified amount, you will not have to pay any more coinsurance for the rest of the calendar year. Once the coinsurance that you pay for:

• An individual family member—either yourself or one of your covered dependents—reaches $3,750 in a calendar year, you will not have to pay any more coinsurance for the rest of the calendar year for that person
• Yourself and your covered child(ren) combined reaches $5,625 in a calendar year, you will not have to pay any more coinsurance for the rest of the calendar year
• Yourself and your covered spouse/partner combined reach $7,500 in a calendar year, you will not have to pay any more coinsurance for the rest of the calendar year
• Yourself and your covered family combined reach $9,375 in a calendar year, you will not have to pay any more coinsurance for the rest of the calendar year
Copayments
The HMO is designed to pay the full cost of most covered services provided either by your PCP or by another participating provider (based on a referral from—or under the supervision of—your PCP). For certain emergency room services and physician office visits—the Plan requires that you pay a specified copayment toward the cost of the service. Once you pay the copayment, the Plan will pay the remaining cost of these services.

Unlimited Lifetime Benefits
No lifetime benefit maximum applies to benefits paid for covered services under the HMO.

Medically Necessary Services
A procedure or supply is considered medically necessary if it is determined to be:
- Appropriate and consistent with the patient’s symptoms and could not have been omitted without adversely affecting the patient’s condition or the quality of the care rendered
- Supplied or performed in accordance with current U.S. standards of medical practice
- Not primarily for the convenience of the patient or the patient’s family or health care provider, and
- An appropriate supply or level of service that can be safely provided.

The term “medically necessary” is usually used to determine whether a medical or insurance plan covers a procedure.

Important! The fact that a physician prescribes, orders, recommends or approves a procedure or supply does not make the procedure or supply medically necessary. Your HMO coverage will not pay the cost of any procedure or supply that is not medically necessary.

Covered Services
The HMO covers a broad range of health care services. These services—and the copayment, if any, that applies to each—are listed in the following table.

In general, the HMO is designed to cover only those services that are medically necessary and that are received from—or provided under the orders, direction or authorized approval of—a covered person’s PCP, except in the case of emergency (see Emergency Coverage at Non-participating Providers, page 20). However, the HMO will also pay benefits toward the cost of non-emergency services provided by a non-participating provider if the services have been ordered or approved by a covered person’s PCP, the services are medically necessary and they cannot be provided by a HMO participating provider.

Note: You do not need prior authorization from the HMO or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Advocate Centered HMO Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Humana (by calling 866.636.2371).
<table>
<thead>
<tr>
<th>Services</th>
<th>Special Provisions</th>
<th>Coinsurance/Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine care for child(ren)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exam</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Vision and Hearing Screening</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Lab Test/X-ray</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Immunization</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Flu/Pneumonia Injection</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Human Papillomavirus (HPV) Vaccination</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Considered routine regardless of diagnosis</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• For child(ren) age 9 to 26</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Routine care for adult(s)</strong></td>
<td>Limit one well-woman exam for each female</td>
<td>None</td>
</tr>
<tr>
<td>• Exam</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Lab Test/X-ray</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Immunization</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Flu/Pneumonia Injection</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Human Papillomavirus (HPV) Vaccination</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Shingles Vaccination</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Mammogram</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Pap Smear</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Colonoscopy, Proctosigmoidoscopy and Sigmoidoscopy Screenings</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Prostate Specific Antigen (PSA) Testing</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Bone Density Scan</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Considered routine regardless of diagnosis submitted</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• For adult age 26 and younger</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• For adult age 60 and older</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• One per calendar year for women age 35 and older</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• One per calendar year for women age 35 and older</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• When performed as hospital outpatient or in an ambulatory surgical center or clinic; includes related services; if performed as part of surgical treatment (e.g., polyp removal, biopsies, etc.) general illness benefits will apply</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• One per calendar year</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>Semiprivate accommodations; private room and intensive care accommodations covered if ordered by your PCP</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Room, Board, General Nursing Care and Medically Necessary Special Diets</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Ancillary Services while Confined—including administration of blood and blood components</td>
<td>Only while services are being provided during an inpatient hospital stay</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Pre-admission Tests</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>• Outpatient Surgery—performed in a hospital</td>
<td>Plan pays 90%, you pay 10%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient MRI, MRA, PET, CAT, SPECT Scan</td>
<td>Plan pays 90%, you pay 10%</td>
<td></td>
</tr>
<tr>
<td>• Other Diagnostic X-ray</td>
<td>$35 per visit</td>
<td></td>
</tr>
</tbody>
</table>

1 Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
### Immediate Care and Emergency Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Special Provisions</th>
<th>Coinsurance/Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Immediate Care Center</td>
<td>• No PCP referral required</td>
<td>$35 copayment at retail based pharmacy clinics like CVS Minute Clinic or Walgreens’ Take Care Clinic</td>
</tr>
<tr>
<td>• Urgent Care Center Facility and Physician</td>
<td>• Must notify PCP within 48 hours</td>
<td>$50 per visit</td>
</tr>
</tbody>
</table>
| • Services Provided in ER of Participating Hospital                     | • Care must be for treatment of an emergency medical condition—that is, acute symptoms of sufficient severity for which absence of treatment could:  
  – place patient’s health (or, in the case of a pregnant woman, an unborn child’s health) in serious jeopardy, or  
  – result in serious impairment to bodily function or serious dysfunction of any bodily organ or part  
  • Covered services include emergency medical screening examination      | $200 per visit (copayment waived if admitted 10% coinsurance)                                      |
| • Services Provided by Participating Physician other than PCP in ER—of Participating Hospital | • Services provided for diagnosis, care or treatment of an emergency medical condition                 | None (after each ER copayment)                                                         |
| • Services Provided in ER of Non-participating Hospital                 | • Services provided for diagnosis, care or treatment of an emergency medical condition                 | $200 per visit (copayment waived if admitted 10% coinsurance)                          |
  • See terms and conditions specified in *Emergency Coverage at Nonparticipating Providers*, page 21

### Basic Physician Services (provided by PCP)

<table>
<thead>
<tr>
<th>Services</th>
<th>Special Provisions</th>
<th>Coinsurance/Copayment</th>
</tr>
</thead>
</table>
| • Physician’s Office Visits                                             | • Services provided in PCP’s office  
  • Must be for diagnosis, care or treatment of sickness or injury                                         | $35 per visit ($50 per visit if performed by a specialist)                               |
| • Physician’s Inpatient Hospital Visits                                 | • Services provided during an inpatient hospital stay  
  • Includes—but not limited to—initial examination of newborn child                                   | None                                                                                  |
| • Allergy Treatments and Materials                                      | • Covered services include allergy serum and allergy injections                                        | None (after each physician’s office visit copayment)                                   |
| • Injections                                                             | • Must be for treatment of sickness or injury                                                          | None (after each physician’s office visit copayment)                                   |
| • Hearing and Vision Screening Exams                                    | • All hearing and vision screening exams (except eye refractions/screenings for contact lenses)       | None (after each physician’s office visit copayment)                                   |
| • Surgery, Anesthesia and Its Administration                             | • Must be performed in PCP’s office                                                                   | None (after each physician’s office visit copayment)                                   |
| • Consultation by a Specialist                                          | • Must have PCP referral                                                                               | None (after each physician’s office visit copayment)                                   |

1 Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
### Other Medical and Physician Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Special Provisions</th>
<th>Coinsurance/ Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic Care</td>
<td>• Exams, x-rays, laboratory, and spinal manipulations and therapy, as determined to be medically necessary by PCP</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>• Radiation Therapy or Respiratory Therapy</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>• Physical, Occupational and Speech Therapy</td>
<td>• Limited to 60 visits per year</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>• Surgery, Anesthesia and Its Administration</td>
<td>• Includes surgical assistance</td>
<td>None</td>
</tr>
<tr>
<td>• Diagnostic Procedures, Tests or X-ray Exams—including interpretation</td>
<td>• For procedures, tests and exams customarily performed in physician’s office</td>
<td>None</td>
</tr>
<tr>
<td>• Casts, Splints, Trusses, Braces (not orthodontia), Crutches, Prosthetic Devices and Routine Medical Supplies</td>
<td>• Replacement is covered only if due to change in prescription or incorrect initial placement</td>
<td>None</td>
</tr>
<tr>
<td>• Durable Medical Equipment – prosthesis – wigs</td>
<td>• Rental fees up to (but not in excess of) purchase price</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td></td>
<td>• Initial purchase, repair and maintenance</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td></td>
<td>• For hair loss resulting from chemotherapy and radiation due to cancer; limit one per lifetime</td>
<td>None</td>
</tr>
<tr>
<td>• Emergency Ambulance Service</td>
<td>• Must be for emergency ambulance service (or as otherwise ordered by PCP) to or from the nearest hospital or ambulatory surgical center qualified to treat sickness, illness or injury</td>
<td>None</td>
</tr>
<tr>
<td>• Outpatient Care and Treatment in an Ambulatory Surgical Center or Clinic</td>
<td></td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Diabetic/Nutritional Counseling</td>
<td></td>
<td>Same as physician’s office visit copayment</td>
</tr>
</tbody>
</table>

### Home Health Care Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Special Provisions</th>
<th>Coinsurance/ Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nursing Care, Physical, Occupational, Respiratory or Speech Therapy, Medical Social Work, Nutrition Services and Home Health Aide Services</td>
<td>• Care must be provided by or under supervision of a registered nurse, licensed practical nurse or a licensed vocational nurse</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Medical Appliances and Equipment, Laboratory Services and Special Meals</td>
<td></td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
</tbody>
</table>

1 Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
<table>
<thead>
<tr>
<th>Services¹</th>
<th>Special Provisions</th>
<th>Coinsurance/ Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Room, Board, Services, Supplies and Routine Care</td>
<td>• Limit of 120 days per calendar year</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Physician Visits</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Infertility Counseling, Testing and Treatment Services</td>
<td>• Follows Illinois state mandate</td>
<td>Same as any other illness</td>
</tr>
<tr>
<td><strong>Tempromandibular Joint (TMJ) Syndrome, Dysfunction Services Disorder and Craniomandibular Jaw (CMJ) Disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Services and Supplies Related to Treatment of TMJ and CMJ Disorders</td>
<td>• Does not include services and supplies which are recognized as dental procedures or appliances</td>
<td>Payable same as any other illness</td>
</tr>
<tr>
<td><strong>Behavioral Health Care—Mental and Nervous Disorders²</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Inpatient Care—room and board, services and supplies | • Services must be provided in a hospital or psychiatric treatment program  
• Must be precertified | Payable same as any other illness |
| • Physician Visits | • Physician services while patient is confined as an inpatient in a hospital or psychiatric treatment program | Payable same as any other illness |
| • Partial Hospitalization—including physician services | • Services must be provided in a hospital or psychiatric treatment program  
• Must be precertified | Payable same as any other illness |
| • Outpatient Care | • Services must be provided in a hospital, psychiatric treatment program or physician’s office  
• Must be precertified | Payable same as any other illness |
| • Physician Office Visits | | $35 copay |
| **Behavioral Health Care—Alcoholism and Drug Dependency²** | | |
| • Detoxification Services | • Inpatient or outpatient, when medically necessary  
• Must be precertified | Payable same as any other illness |
| • Inpatient Rehabilitation—including physician’s services | • Services must be provided in a hospital or psychiatric treatment program  
• Must be precertified | Payable same as any other illness |
| • Outpatient Rehabilitation Visits | • Services must be provided in a hospital or psychiatric treatment program  
• Must be precertified | Payable same as any other illness |

¹ Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
² Must be pre-certified; call 800.454.6455.
<table>
<thead>
<tr>
<th>Services¹</th>
<th>Special Provisions</th>
<th>Coinsurance/Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ Transplant Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Room, Board and General Nursing Care</td>
<td>Covered the same as hospital expenses for care and treatment of any other covered illness or injury—must be pre-certified</td>
<td>Plan pays 90%, you pay 10%</td>
</tr>
<tr>
<td>• Physician Services</td>
<td>Covered the same as physician expenses for care and treatment of any other covered illness or injury</td>
<td>$50 per office visit; none for inpatient hospital visits</td>
</tr>
<tr>
<td>• Organ Acquisition and Donor Costs</td>
<td>No benefits will be paid by the Plan if these costs are payable—in whole or in part—by any other group insurance plan, insurance company, organization or person other than the donor’s family or estate</td>
<td>None</td>
</tr>
<tr>
<td>• Direct, Non-medical Costs—for patient</td>
<td>Benefits available only if patient lives more than 100 miles from an approved transplant facility</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Benefits include transportation to and from approved transplant facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All benefits subject to approval by Humana</td>
<td></td>
</tr>
<tr>
<td>• Direct, Non-medical Costs—for family member(s)</td>
<td>Benefits available only if family member(s) live(s) more than 100 miles from the transplant facility, limited to 10,000 miles</td>
<td>None</td>
</tr>
</tbody>
</table>

**Hospice Care Services—Inpatient and Outpatient**

None

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¹ Except in an emergency, benefits will be paid ONLY for services received from—or based on a referral from—your PCP.
Newborns’ and Mothers’ Health Protection Act
The HMO intends to comply with the provisions of the Newborns’ and Mothers’ Health Protection Act. If you, a covered spouse or a dependent female child is having a baby, your HMO coverage generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth to less than:
• 48 hours—following a normal vaginal delivery, or
• 96 hours—following a cesarean section.

Additionally, lengths of stay that are expected to fall within these time periods do not have to be pre-authorized by your medical coverage. However, additional days of hospitalization exceeding these timeframes must be pre-authorized to ensure maximum benefits. In addition, if the mother and the attending physician agree, the mother or newborn may be discharged earlier than 48 hours (or 96 hours, as applicable).

Women’s Health and Cancer Rights Act of 1998
The HMO intends to comply with the provisions of the Women’s Health and Cancer Rights Act of 1998.

Your Advocate-sponsored medical coverage provides benefits for mastectomy-related services and the complications resulting from a mastectomy (including lymphedema). These benefits include reconstruction and surgery to achieve breast symmetry and prostheses. Normal copayments, deductibles and coinsurance under your HMO coverage may apply.

Referral Health Services Provided by Non-participating Providers
In the event your PCP orders or approves a medically necessary health care service that cannot be provided by or through a participating provider of the HMO network, the Plan will pay benefits toward the cost of this service if treatment is received from a non-participating provider. These services are subject to all of the terms, conditions, limitations and exclusions of the Plan.

Emergency Coverage at Non-participating Providers
The HMO will pay benefits toward the cost of emergency care services received from a non-participating provider—subject to the same terms, conditions, limitations and exclusions of the HMO coverage.

As soon as possible after emergency services are provided by a non-participating provider, the patient should notify the Plan Administrator and provide full details of the emergency care services received.

Benefits will be paid only for the use of the emergency room for treatment of an emergency medical condition, screening and stabilization. Benefits will be paid for follow-up or continued care services or prescriptions only if these services are authorized by the patient’s PCP.

Note: If the patient is hospitalized following the emergency treatment, the HMO may require that the patient transfer to a participating hospital as soon as it is medically appropriate (in the opinion of the attending physician).
Out-of-Area Coverage
If you or a dependent are traveling outside the HMO service area or if you are covering a student attending college who lives outside the HMO service area, the HMO will pay benefits toward the cost of emergency care services that the child receives from a non-participating provider.

The HMO will cover non-emergency or recurring services (physical therapy, allergy shots, etc.) received outside the service area for yourself or a dependent based on a referral from the PCP.

Morbid Obesity
Services in connection with bariatric surgery for morbid obesity will be covered under this HMO coverage, provided these services have been pre-approved by the Plan Administrator or authorized by the PCP. Bariatric surgery includes—but is not limited to—gastric bypass and lap banding. Benefits will be paid the same as for any other illness.

Organ Transplant Services
Organ transplants are subject to prior approval—in writing—by the Plan Administrator’s Transplant Management Department. You or your PCP must notify the Transplant Management Department in advance of your need for an initial evaluation and provide a reasonable opportunity for the department to review the clinical results of your evaluation.

Covered transplant services include care and treatment received for—or in connection with—one of the following transplant procedures:
- Kidney
- Bone marrow
- Heart valve
- Heart
- Lung
- Heart/lung
- Liver, or
- Pancreas.

Note: Corneal transplants and porcine heart valve implants—which are tissues rather than organs—are covered under the HMO’s regular benefits and are subject to the same terms, conditions and limitations described for covered services in this summary (see Covered Services, page 14).

Services That Are Not Covered
This section describes general services that are not covered by the HMO. It is not, however, intended as an all-inclusive listing. Please contact the HMO if you have any questions.

Charges for more than one item of equipment for the same or similar purpose are not covered under the HMO. Benefits also will not be provided for services, supplies or treatments that are not specifically provided for in the Plan document, required by law or that are for:
- Any service, supply, care or treatment provided to you or a covered dependent without the authorization of the patient’s PCP—except in cases of emergency and OB/GYN care (as specified in this summary)
- Care for conditions that state or local law requires to be treated in a public facility
- Services for which charges would not have been incurred if you had no coverage or for any charge for which you would not be legally required to pay
- Education, training or medical services provided by your parent, spouse, brother, sister or child
- Experimental drugs or substances not approved by the Food and Drug Administration (FDA), drugs or substances used for other than FDA-approved indications or drugs labeled “Caution—limited by Federal law to investigational use”
- Prescription drugs, including insulin and syringes, vitamins, birth control pills and non-prescription drugs or medicines—except for diabetes supplies and any other prescription drugs that must be covered according to applicable law.
• Treatment, services, supplies or surgery that is not medically necessary
• The purchase or fitting of hearing aids or advice on their care
• Weekend non-emergency hospital admissions
• Sex change services or reversal of elective sterilization
• Any drug, biological product, device, medical treatment or procedure which is experimental or investigational as defined by the HMO or which is not covered as experimental or investigational by the HCFA Medicare Coverage Issues Manual
• Any drug, biological product or device which cannot be lawfully marketed without FDA approval and which lacks such approval at the time of its use or proposed use
• Any drug or biological product categorized as a Treatment Investigational New Drug by the FDA or as a Group C Treatment Protocol Drug by the U.S. National Cancer Institute at the time of its use or proposed use, including:
  – ambulatory blood pressure monitor
  – refractive keratoplasty or radial keratotomy
  – positron emission tomography (PET) scans
  – transurethral balloon dilation of prostate
  – immunotherapy for recurrent abortion
  – chemonucleolysis
  – biliary lithotripsy
  – home uterine activity monitor
  – immunotherapy for food allergy, and
  – percutaneous lumbar discectomy
• Cosmetic plastic surgery—unless to correct a functional impairment or for the purpose of breast reconstruction when you or a covered dependent has undergone a medically necessary mastectomy

• Services and supplies for dental care, including braces and dental appliances and oral surgery—unless for treatment of temporomandibular joint (TMJ) syndrome or craniomandibular jaw disorder (CMJ), required due to surgical removal of a tumor or lesion in the mouth or received in connection with an injury for which care and treatment began within 90 days, are provided within 24 months of the date the injury occurred, you or your dependent are continuously covered by the Plan during that time and the injury was not the result of biting or chewing
• Dental implants or any treatment related to preparation or fitting of dentures
• Services and supplies for treatment of TMJ or CMJ that are recognized as dental procedures—including extraction of teeth and application of orthodontic devices
• Care and treatment of the feet—unless medically necessary, as determined by the patient’s PCP
• Orthotic devices—unless custom-fitted to the patient—and repair of orthotic devices
• Any service, supply or treatment connected with custodial care
• Enrollment in a health, athletic or similar club or a weight loss or similar program
• Purchase or rental of common household supplies—such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds
• Purchase or rental of motorized transportation equipment, escalators or elevators, saunas or swimming pools or professional medical equipment such as blood pressure kits, supplies or attachments for any of these
• Convenience or personal care services—such as use of telephone or television
• Vision training
• Acupuncture—unless medically necessary and appropriate, and provided within the scope of the acupuncturist’s license, treatment is based upon a referral from a licensed physician and the acupuncture is performed in lieu of generally accepted anesthesia practices.
• Routine physical examinations—when required for employment, school or an insurance company.
• Eye refractions.
• Any service or supply received in—or in connection with—a Veteran’s Hospital or other government facility or program due to—or in connection with—a condition or disability resulting from service in an armed force or military and for which you have no legal liability for payment.
• Services and supplies which are:
  – rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services,
  – extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities, or for mental retardation,
  – for marriage counseling, occupational counseling or sex therapy, or
  – for mental illnesses which—according to generally accepted professional standards—are not usually amenable to favorable modification.
• Services provided prior to the effective date—or after the termination date—of your coverage under this HMO option, and
• Any service, supply, care or treatment that is not described in this summary, the Plan document or any rider attached to it as a covered service, supply, care or treatment.

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**Prescription Benefits**

If you choose this HMO coverage option, you will be covered automatically under the Advocate Prescription Benefits Program, which is administered by OptumRx. It provides benefits for prescription medicines purchased at retail pharmacies in the OptumRx network of participating pharmacies (including major chains such as Osco, Walgreens, and Target) or through the OptumRx’s mail order program.

After you pay a per-prescription copayment, this program will pay the full cost of your prescription medicines.

Certain limitations and exclusions apply under the Prescription Benefits Program, and some medications—such as certain amphetamines, anabolic steroids, cosmetic hair removal products—are excluded from this coverage.

More detailed information about this program, including the complete Performance Drug Listing (PDL) of preferred brand name drugs, is available online at advocatebenefits.com (click on **Benefits Information > Prescription Benefits**).

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**Important!** If a generic equivalent is available and you have the prescription filled with a non-preferred brand drug, you will pay—in addition to the copayment—the difference between the cost of the non-preferred brand drug and the generic drug.
Making a Claim

As described below, you must follow the procedures under this section to “exhaust” your administrative remedies under the Plan before you can pursue an external review and/or other legal action.

Payment of Claims
Generally, direct payments will be made to the hospital, clinic, or physician’s office that provided your care or services, except that in some instances (e.g., for care or services received by a non-participating provider), you may be required to pay the provider and then submit a claim to the HMO administrator. The HMO administrator reserves the right to request any information required to determine benefits or to process a claim. You or the provider of the services will be contacted if additional information is needed to process your claim.

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Lexington, KY 40512-4546

When an associate’s child is subject to a medical child support order, the HMO administrator will make reimbursement of eligible expenses paid by you, the child, the child’s non-employee custodial parent, or legal guardian, to that person as provided in the medical child support order.

Payment of benefits under the Plan will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Eligibility Determinations
Determinations of eligibility to participate in the Plan will be made by the Plan Administrator rather than the HMO administrator, but will otherwise generally follow the same process as for claims decisions that is outlined in this booklet (except that the external review process does not apply to eligibility determinations). If you have questions about your, your spouse’s (or domestic partner’s or civil union partner’s) and/or your child’s eligibility, you should contact Advocate Benefits Service Center at 1.800.775.4784. If you would like to request a formal determination of your (or your dependent’s) eligibility to participate in the Plan or believe that a determination of your (or your dependent’s) eligibility to participate in the Plan was incorrect, please contact:

Plan Administrator
(Attn: Eligibility Determinations)
Advocate Health Care Network
3075 Highland Parkway, Suite 600
Downers Grove, Illinois 60515

Claims Decisions
After submission of a claim by you, your beneficiary or your authorized representative acting on behalf of you (each a “claimant”), the HMO administrator will notify the claimant of the HMO administrator’s decision in writing or by acceptable electronic means, in a culturally and linguistically appropriate manner, and within a reasonable time, as follows:

Pre-Service Claims
The HMO administrator will notify the claimant of a favorable or adverse determination of a claim for medical care for which the Plan requires advance approval (including pre-certification or utilization review) within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the pre-service claim.

However, this period may be extended by an additional 15 days if the HMO administrator determines that an extension is necessary due to matters beyond the control of the administrator. The HMO administrator will notify the claimant of the extension before the end of the initial 15-day period, the reason(s) the extension is necessary, and the date by which the HMO administrator expects to make a decision.
If the reason for the extension is because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have at least 45 days from the date of the notice to provide the specified information. If the claimant’s pre-service claim does not follow the procedures for filing a pre-service claim, the claimant will receive notice from the HMO administrator within 5 days following the failure.

**Urgent Care Claims**

The HMO administrator will determine whether a claim is an urgent care claim, with deference to the determination attending provider. The HMO administrator may require the claimant to clarify the medical urgency and circumstances that support the urgent care claim for expedited decision-making.

The HMO administrator will notify the claimant of a favorable or adverse determination as soon as possible (taking into account the medical urgency particular to the participant’s situation) but not later than 72 hours after receipt of the urgent care claim.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan, the HMO administrator will notify the claimant as soon as possible, but not more than 24 hours after receipt of the urgent care claim. The notice will describe the specific information necessary to complete the claim.

The claimant will then have a reasonable amount of time (up to 48 hours) to provide the necessary information. The HMO administrator will notify the claimant of the urgent care claim determination as soon as possible, but in no event more than 48 hours after the earlier of:

- The receipt of the specified information; or
- The end of the 48-hour period given to the claimant to provide the specified additional information.

The claimant may be notified of this determination orally, but if so, the HMO administrator will also send a written or electronic notice of the determination within 3 days of the oral notice.

If the claimant’s urgent care claim does not follow the procedures for filing an urgent care claim, the claimant will receive a notice from the HMO administrator within 24 hours following the failure.

**Concurrent Care Decisions**

The HMO administrator will notify the claimant of a concurrent care decision that involves a reduction in or termination of the medical care that the participant is receiving (a participant’s current course of treatment). The HMO administrator will provide the notice sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A claimant’s request to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the HMO administrator as soon as possible, taking into account the medical urgency particular to the participant’s situation. The HMO administrator will notify the claimant of the benefit determination, whether favorable or adverse, within 24 hours after receipt of the claim, but the claimant must have submitted the claim for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Post-Service Claims**

The HMO administrator will notify the claimant of a determination, whether favorable or adverse, of a claim that is filed after the participant received the medical care within a reasonable time, but not later than 30 days after receipt of the claim.
However, this period may be extended by an additional 15 days if the HMO administrator determines that the extension is necessary due to matters beyond the control of the administrator. The HMO administrator will notify the claimant of the extension before the end of the initial 30-day period, the reason(s) the extension is necessary, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the claimant’s failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have at least 45 days from the date of the notice to provide the specified information.

Initial Denial Notices
A claim denial notice from the HMO administrator will include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability of the diagnosis and treatment codes and their corresponding meanings (if you request the diagnosis and treatment codes, this information will be provided to you as soon as practicable following your request);
- The specific reason or reasons for the denial;
- The code assigned to the reason for the denial (along with the meaning of the code);
- A description of the Plan’s standard, if any, that was used in denying the claim;
- The specific plan provisions on which the determination is based;
- A description of the internal appeals procedures and external review processes applicable to the Plan (including information about how to appeal a denial and the time limits applicable to such procedures);
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- Contact information for any office of health insurance consumer assistance or ombudsman available to assist the claimant with the internal claims and appeals and external review processes; and
- A description of any internal rule, protocol or similar criterion that the HMO administrator relied on to deny the claim and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit under the Plan, the notice will provide either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the participant’s medical circumstances) or a statement that such explanation will be provided free of charge upon request.

In the case of a denial of an urgent care claim, the notice will provide a description of the Plan’s expedited review procedures applicable to such claims.

Appeals of Adverse Determinations
A claimant must appeal a claim denial within 180 days after receiving written notice of the denial (or partial denial). A claimant must make an appeal of the initial claim denial by means of written application, in person, or by mail (postage prepaid), addressed to:

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Lexington, KY 40512-4546

However, in the case of an appeal of a claim denial involving urgent care, the claimant may make a request for an expedited appeal of a claim denial orally or in writing and all necessary information will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expedited method.
A claimant may submit written comments, documents, records, and other information and, upon request and free of charge, will be given reasonable access to (and copies of) all documents, records and other information relevant to the claim. Appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination on appeal will also take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, regardless of whether such information or documentation was submitted or considered in the initial benefit determination. Coverage will continue under the Plan pending the outcome of the appeal, to the extent required by applicable law.

If the denial was based (in whole or in part) on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the medical field involved in the medical judgment. The consulting health care professional will not be the same person who was consulted in connection with the initial denial or a subordinate of that person. The HMO administrator reviewing the appeal will identify any medical or vocational experts whose advice was obtained in connection with the denial being appealed, regardless of whether the advice was relied upon in denying the claim.

If any new or additional evidence is considered, relied upon or generated by the plan as part of the appeal review or if the determination is based on any new or additional rationale, this evidence and rationale will be provided (free of charge) to the claimant as soon as possible and sufficiently in advance of the date on which to give the claimant a reasonable opportunity to respond prior to that date.

Time Periods for Decisions on Appeal
Appeals of claim denials will be decided and notice of the decision will be provided as follows:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Decision Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claims</td>
<td>As soon as possible, but not later than 72 hours after the claimant filed the appeal request.</td>
</tr>
<tr>
<td>Pre-Service Claims</td>
<td>Within a reasonable period, but not later than 15 days after the claimant filed the appeal request.</td>
</tr>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period, but not later than 30 days after the claimant filed the appeal request.</td>
</tr>
<tr>
<td>Concurrent Care Decisions</td>
<td>Within the time periods specified above, depending on the type of claim involved.</td>
</tr>
</tbody>
</table>

Appeal Denial Notices
A notice of a denial on appeal will include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability of the diagnosis and treatment codes and their corresponding meanings (if you request the diagnosis and treatment codes, this information will be provided to you as soon as practicable following your request);
- The specific reason or reasons for the denial of an appealed claim;
- The code assigned to the reason for the denial (along with the meaning of the code);
- A description of the Plan’s standard, if any, that was used in denying the appealed claim (including a discussion of the decision);
- The specific plan provisions on which the determination is based;
- A description of this Plan’s voluntary appeal procedures (if any), the Plan’s internal claim and appeal and external review procedures (including how to initiate a second level appeal), and the time limits applicable to such procedures;
- A statement that, upon request and free of charge, the claimant is entitled to reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
• Contact information for any office of health insurance consumer assistance or ombudsman available to assist the claimant with the internal claims and appeals and external review processes; and
• A description of any internal plan rule, protocol or similar criterion that was relied on to deny the appeal and a statement that a copy of such rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

If the appeal denial is based on medical necessity, experimental, or a similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the participant’s medical circumstances) or a statement that such explanation will be provided free of charge upon request.

Second Appeal of a Claim Denial
A claimant may appeal a denial on appeal of a pre-service claim or post-service claim, but the claimant must do so within 90 days (or any longer period that may be specified by the HMO administrator) after receiving written notice of the denial (or partial denial) of the appeal. All of the procedures for a first level of appeal of a claim denial apply for the second level appeal of a claim denial, except that the second level appeal will be decided and notice of the decision will be provided as follows:

<table>
<thead>
<tr>
<th>Pre-Service Claims</th>
<th>Within a reasonable period, but not later than 15 days after the claimant filed the second level appeal request.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period, but not later than 30 days after the claimant filed the second level appeal request.</td>
</tr>
</tbody>
</table>

External Review Process
Beginning January 1, 2011, a claimant may request an external review of certain types of denials within 4 months after the receipt of the denial notice. A claimant may request an external review of a rescission of coverage under the Plan, or of a denial that involved “medical judgment.” Examples of “medical judgment” include determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit and determinations that a treatment is experimental or investigational. This external review process is not available for a claim or appeal denial related to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan and is not available until the claimant has exhausted (unless the claimant is not required to exhaust) the applicable internal claims and appeals process under the Plan.

To request an external review of a denial by Humana, contact:
Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

Within 5 business days of receiving the claimant’s external review request, the HMO administrator will complete a preliminary review of this request and will provide the claimant with written notice within 1 business day after completing its preliminary review. The preliminary review determines whether (i) the claimant is or was covered under the Plan at the time the health care item or service was requested or provided, (ii) the denial relates to the claimant’s failure to meet the requirements for eligibility under the Plan, (iii) the claimant has exhausted (or is not required to exhaust) the Plan’s internal appeal process, and (iv) the claimant has provided all of the information and forms required to process an external review. If the claimant’s request is complete but the denial is not eligible for external review, the notice will include the reason(s) for ineligibility and the contact information for the Employee Benefits Security Administration (1.866.444.3272). If the request is not complete, the notice will describe the information or materials needed to complete the request.
the request. The claimant will have until the later of the initial 4-month filing period or the 48-hour period after the receipt of the notice to provide such information or materials.

If the claimant’s request is eligible for external review, an independent review organization (IRO) will be assigned to conduct the external review and the IRO will timely notify the claimant that the request is eligible for and has been accepted for external review. Within 10 business days after the receipt of the notice, the claimant may submit to the IRO any additional information that the IRO will consider when conducting the external review. The IRO will provide the HMO administrator with any information submitted by the claimant within 1 business day after it receives the information and the HMO administrator may reconsider its denial. If the HMO administrator decides to reverse its denial, it will provide written notice of its decision to the claimant and the IRO within 1 business day of completing its reconsideration and the IRO will terminate the external review upon receiving this notice.

The IRO will review all of the information and documentation that it timely receives and will provide written notice of its final decision within 45 days after the IRO receives the claimant’s request for an external review. This notice to the claimant will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (such as date of service, the health care provider, the claim amount, and the diagnosis code, the treatment code and the meanings of these codes);
- The date the IRO received the assignment to conduct the external review and the date the IRO made its decision;
- References to the evidence or documentation (including the specific coverage provisions and evidence-based standards) the IRO considered in making its decision;
- A discussion of the principal reason(s) for the IRO’s decision (including the rational for its decision and any evidence based standards that were relied on in making its decision);
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information (including the phone number) for any applicable office of health insurance consumer assistance or ombudsman that may be available to assist the claimant.

Upon receipt of a notice that the IRO has reversed the claim or appeal denial, the Plan will immediately provide coverage or payment for the denied claim.

Expedited External Review Process
The external review process described above may be conducted on an expedited basis if:

- The claim denial involves a medical condition for which the timeframe for completing an urgent care claim internal appeal (provided the claimant has filed an internal appeal for an urgent care claim denial) would seriously jeopardize the life or health of the participant or would jeopardize the participant’s ability to regain maximum function, or
- The denial of the internal appeal involves a medical condition for which the timeframe for completing a standard external appeal would seriously jeopardize the life or health of the participant or would jeopardize the participant’s ability to regain maximum function, or
- The denial of the internal appeal concerned an admission, availability of care, continued stay or health care item or service for which the participant received emergency services but has not been discharged from a facility.
Under an expedited external review process, the HMO administrator will complete its preliminary review immediately and will immediately thereafter send a notice to the claimant of the request’s eligibility for an expedited external review. The HMO administrator will then assign an IRO to such request if it is eligible for an expedited external review and will provide or transmit all necessary documentation and information considered in denying the claim or appeal by any available expeditious method (such as electronically or by telephone or fax). The IRO will consider the information or documentation under the procedures for a standard external review, but will complete the expedited review and provide notification to the claimant as expeditiously as the participant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If this notice is not in writing, the IRO will provide written confirmation of the decision to the claimant within 48 hours after providing that notice.

Assistance
If you need assistance with the internal claims and appeals or the external review processes that are described in this section, you may contact the Illinois ombudsman program at 1.877.527.9431, or call the number on the back of your coverage ID card for further information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1.866.444.3272.

Exhaustion
Upon completion of the claims and appeals and external review process under this section, the claimant will have exhausted his or her administrative remedies under this Plan. If the HMO administrator fails to complete a claim determination or an appeal according to the requirements set forth above (other than a failure that is de minimis, non-prejudicial, due to good cause or matters beyond the HMO administrator’s control, in the context of an ongoing, good faith exchange of information, and not reflective of a pattern or practice of non-compliance), the claimant may be treated as if he or she has exhausted the internal claims and appeals process and he or she may request an external review or pursue any available remedies under applicable law. No action at law or in equity may be brought with respect to Plan benefits until all rights under this Plan have been exhausted and any such action must be brought no later than two years from the date of the HMO administrator’s final decision upon review of a second level appeal or the expiration of the applicable limitations period under applicable law (whichever is earlier).

In addition, any suit or claim must be filed in the Circuit Courts for DuPage County, Illinois (unless federal jurisdiction applies, in which case the suit or claim should be brought in the Northern District of Illinois, Eastern Division).

How do I appeal a behavior health claim?
The pre-certification process for behavioral illness follows the policies of AXCES. For all appeals for behavioral health, contact AXCES Behavioral Health at 800.454.6455.
Other Plan Information

When Medical Coverage Ends
Your Coverage
You (and your dependents’) coverage under the HMO will end on the earliest of:
• The last day of the month in which your employment with the Advocate Companies ends, including your retirement;
• The last day of the month in which you change to an employment status that is not eligible for HMO coverage;
• The date you enter the armed forces of any country, except as provided under the Uniformed Services Employment and Reemployment Rights Act (USERRA) (see Coverage During a Military Leave of Absence, page 35);
• For your dependents, the date the dependent ceases to be a covered dependent;
• The last day of the pay period if you fail to pay the required contributions for coverage;
• The date you die (or for your dependents, the last day of the calendar month in which you die); or
• The date Advocate discontinues the HMO coverage option (or the Plan).

Non-Duplication of Benefits
If you choose the HMO coverage option, include a family member under your coverage and this family member also has coverage under another plan, or you have coverage under another plan or Medicare, your Advocate coverage may provide primary or secondary coverage for this family member under the “non-duplication” of benefits provision.

Important! If you have HMO coverage as either your primary or secondary coverage, you must follow that HMO’s requirements in order to receive any other medical benefits from that plan.

Here are some guidelines for determining whether a plan is primary or secondary:
• The Plan is “primary” if you are the employee and an Advocate Company is your employer.
• If you cover your spouse as a dependent under your Advocate coverage and your spouse also has medical coverage through his or her employer, your spouse’s plan will be his or her primary plan, and your Advocate coverage will be secondary.
• If you cover your eligible children as dependents under Advocate coverage and your spouse also covers them as dependents under his or her employer plan, determination of which plan is primary will be based on the “birthday rule.” Under this rule, the coverage of the parent who has the birthday month that falls earlier in the year (e.g., March vs. August) will be the primary health plan for all dependent children.
• If you are working and covered by Medicare, your Advocate coverage will be primary and Medicare will be secondary.

If you are legally separated or divorced, the plan with primary payment responsibility will be determined as follows:
• The plan of the parent with that responsibility will be primary;
• The plan of the stepparent married to that parent, if any, will pay second; and
• The plan of the other natural parent will pay third.
You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

**Important!** Each year, Advocate’s benefit administrators will ask you to update information regarding the health coverage that you and your covered dependents have, including any coverage that you may have in addition to the Advocate plans. You will need to respond to this request by the deadline given; if you don’t, your claims will be “pended.” Any claims that you file for benefits from the plans after that date will be paid only if you have responded to the request. No further benefits will be paid until your response is received.

**Rights of the Administrators**

If the Plan or HMO makes larger benefit payments than are necessary, the Plan has the right to recover those excess payments from any insurance company, any organization and/or any persons to or for whom those payments were made. The Plan or HMO also may pay another organization an amount it determines is warranted if payments that should have been made by the Plan have been made by another organization under any other group program.

The HMO administrator has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in the HMO, you have agreed to furnish any information the Plan requires to enforce these provisions.

**Reimbursement/Subrogation**

You and your covered dependents agree that by participating in and receiving benefits under the Plan:

- This Plan shall be repaid the full amount of the covered expenses it pays (or expects to pay) from any amount received from others for the sickness or injuries which necessitated such covered expenses. Without limitation, “amounts received from others” specifically includes, but is not limited to, liability insurance, worker’s compensation, uninsured motorists, underinsured motorists, “no-fault” and automobile med-pay payments or recovery from any identifiable fund regardless of whether the participant was made whole.
- This Plan’s right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the Plan participant.
- The right to recover amounts from others for the injuries or losses which necessitate covered expenses is jointly owned by this Plan and the participant. This Plan is subrogated to the participant’s rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse this Plan as prescribed above; this Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which this Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the Plan participant. A Plan participant for purposes of the Plan’s reimbursement and subrogation rights means a covered associate and his or her covered dependents as well as any of those individuals’ guardian, estate or other legal representative.
• The Plan participant will cooperate with the Plan Administrator in any effort to recover from others for the sickness and injuries which necessitate covered expense payments by this Plan. The participant will notify this Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of this Plan. Neither this Plan nor the participant shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

Right to Collect Needed Information
You must cooperate with the Plan Administrator and when asked, assist the Plan Administrator by:
• Authorizing the release of medical information including the names of all providers from whom you received medical attention;
• Obtaining medical information and/or records from any provider as requested by the Plan Administrator;
• Providing information regarding the circumstances of your sickness or injury;
• Providing information about other insurance coverage and benefits, including information related to any injury or sickness for which another party may be liable to pay compensation or benefits; and
• Providing information the Plan Administrator requests to administer this Plan.

Duty to Cooperate in Good Faith
You are obliged to cooperate with the Plan Administrator in order to protect this Plan’s recovery rights. Cooperation includes promptly notifying the Plan Administrator that you may have a claim, providing the Plan Administrator relevant information, and signing and delivering such documents as the Plan Administrator reasonably request to secure this Plan’s recovery rights. You agree to obtain this Plan’s consent before releasing any party from liability for payment of medical expenses. You agree to provide the Plan Administrator with a copy of any summons, complaint or any other process serviced in any lawsuit in which you seek to recover compensation for your injury or sickness and its treatment.

You will do whatever is necessary to enable the Plan Administrator to enforce this Plan’s recovery rights and will do nothing after loss to prejudice this Plan’s recovery rights.

You agree that you will not attempt to avoid this Plan’s recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the covered person to provide Humana such notice or cooperation, or any action by the covered person resulting in prejudice to this Plan’s rights will be a material breach of this Plan and will result in the covered person being personally responsible to make repayment. In such an event, this Plan may deduct from any pending or subsequent claim made under this Plan any amounts the covered person owes this Plan until such time as cooperation is provided and the prejudice ceases.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
This Federal law imposes requirements on employer health plans concerning the disclosure of certain individual health information, known as Protected Health Information (PHI). PHI includes individually identifiable health information that relates to your past, present or future health treatment, or payment for health care services. This HMO will be administered to comply with HIPAA.

Additional information is available online at advocatebenefits.com (click on Benefits Information > HIPAA).

Integrating Benefits with Medicare
Individuals who are eligible for Medicare receive Medicare Part A at no cost. Participation in Medicare Part B is available as voluntary coverage. If you become entitled to Medicare and are still actively at work, you may continue coverage under the HMO at the same level of benefits and contribution rates. This also applies to dependents who become entitled to Medicare while you are still actively at work.

If you and/or your dependent also enroll in Medicare, the HMO will be the primary plan and Medicare will provide you with secondary health care coverage. If you and/or your dependents choose to discontinue coverage under the HMO and enroll in Medicare, no benefits will be payable from the HMO.

Special integration rules apply for persons entitled to Medicare by reason of disability or with end-stage renal disease.

Medicare Coverage for Disabled Individuals
If you or your eligible dependent is totally disabled and not currently actively employed, Medicare will provide primary medical coverage. Once you or your dependent is determined to be totally disabled by Social Security rules, the disabled individual should apply for coverage under Medicare Parts A and B. In these situations your medical plan coverage option is the secondary payor.

Medicare Coverage for Individuals with End-Stage Renal Disease
In all situations involving end-stage renal disease (ESRD)—regardless of age or Medicare status—your medical plan coverage option is the primary payor of medical expenses for the first 30 months of entitlement to Medicare because of ESRD. After the first 30 months of ESRD entitlement, Medicare is the primary payor, and your Advocate medical plan coverage option is the secondary payor.

Assignment of Benefits
A Qualified Medical Child Support Order (QMCSO) is a court order that gives your child the right to be covered under the HMO (or another Advocate-sponsored medical plan option. A typical reason courts issue a QMCSO is to protect benefit coverage for children in cases of divorce. The Plan Administrator, in its sole discretion, will determine whether a court order is qualified.

You will be notified if you are covered under the HMO and Advocate receives a QMCSO that affects you. Coverage will end once the order is no longer in effect or if comparable coverage is provided to the child without interruption.
Coverage During Leaves and Disability

Coverage During a Family Medical Leave Act (FMLA) Absence
If an Advocate company grants you an approved FMLA leave, medical coverage for you and your covered dependents will continue during your approved leave for up to 12 weeks during any 12-month period, as long as you continue to pay your required contributions. If you are on a paid leave, including disability, your contributions will be taken from your pay, as usual. If you are on an unpaid leave, you must pay your contributions according to procedures established by the Plan Administrator.

Coverage will end if:
• You fail to make any required contribution within 30 days after the date the contribution is due
• Advocate determines your approved FMLA leave is ended, or
• You are no longer eligible for coverage.

If you have continued coverage and gain a new dependent during an approved FMLA leave, your dependent will be eligible for coverage as if you were actively at work as long as you add the dependent to your coverage within 90 days from the date you gain the new dependent.

If you do not maintain coverage during an FMLA leave and return to active employment after your leave is over, your prior coverage and that of your covered dependents can be resumed with no waiting period. However, you must make a request for this coverage within 90 days of the date Advocate determines your leave to be over. If you do not make this request within the 90-day period, coverage will not be available again until the next annual enrollment period (unless you have a qualified work, family or eligible life status change).

If Advocate determines your FMLA leave is over and your coverage ends, you will be eligible for continuation of coverage as if you had ended employment on that day (see Continuation of Coverage, page 37).

Additional information about FMLA leaves is available online at advocatebenefits.com (click on Benefits Information > Leave of Absence > Family and Medical Leave Act).

Coverage During a Military Leave of Absence
You can continue your coverage under the HMO if you leave for military service for less than 31 days—as long as you continue to make your contributions for coverage. If your military leave lasts longer than 31 days, you can continue your coverage until the earlier of:
• The end of the 18-month period beginning on the date you leave for military service, or
• The day your reemployment rights under the USERRA end.

If your coverage under the HMO is terminated while you are in military service, it will be reinstated when you return if you return from military service within the time required under USERRA.

Additional information about coverage during a military leave of absence is available online at advocatebenefits.com (click on Benefits Information > Leave of Absence > Leave of Absence Policy).
Coverage If You Become Disabled

If you are receiving disability benefits, you may continue your medical coverage for up to 12 months after becoming disabled, as long as you continue to pay your required contributions. You must pay your portion of the cost through payroll deduction, by personal check or money order on an ongoing basis or your coverage will be discontinued. Benefit elections and payments must be kept current, or your coverage will be discontinued.

What happens if I am no longer eligible for benefits?

The HMO allows covered associates and their covered family members to continue certain medical benefit coverage at their own expense when they would otherwise lose coverage (see Continuation of Coverage below).

Continuation of Coverage

The Plan allows covered associates and their covered family members to continue certain types of health care coverage at their own expense when they would otherwise lose coverage.

Qualifying Events for Associates and Covered Dependents

Coverage can continue for you and/or your covered family members for 18 months if you experience a qualifying event. Qualifying events can occur when you lose your coverage because:

• Your work hours are reduced or you otherwise lose eligibility for health benefits,
• You resign,
• Your employment with the Advocate Companies ends (except for gross misconduct),
• You are laid off from work,
• You take a leave of absence, or
• You retire.

Continuing coverage also is available to your covered family members if their coverage ends because:

• You get a divorce, an annulment or become legally separated,
• You terminate employment with the Advocate Companies (for reasons other than gross misconduct),
• You experience a reduction in work hours,
• Your dependent is no longer eligible under the Plan, or
• You become eligible for Medicare.

Your covered family members can also choose to continue coverage for up to 36 months if they lose their eligibility for coverage (for example, your dependent reaches the dependent age limit). If one of these qualifying events occurs while a dependent is already continuing coverage, his or her coverage may be extended for up to 36 months from the date of the first event.

To be eligible for this extension, you or your dependents must notify the continuation of coverage administrator within 60 days of the second event.

Note: If you have a newborn child or a child is placed for adoption with you while you are covered under continuing coverage, that child can also receive continuing coverage for the duration of your coverage. You must notify the Plan Administrator within 90 days of the birth or placement for adoption for the child to be covered as of the date of birth or placement for adoption. In this case, the child will have the same rights as any dependent covered immediately prior to your eligibility for continuing coverage.
Continuation of Coverage and Disability
If you are disabled, as determined by the Social Security Administration, on the date you lose coverage or you become disabled during the first 60 days of continuing coverage, you can continue coverage for a total of 29 months (that is, for 11 additional months). You must notify the continuation of coverage administrator within 60 days of the determination of disability, and this notice must be received within the first 18 months of coverage.

Your Benefits
If you elect to continue coverage under the HMO, you receive generally the same benefits as active associates, and you are subject to the same limitations and exclusions, including expenses not covered and coordination of benefits.

Applying for Continuation of Coverage
If you become eligible for continuation of coverage, you may request that information about this coverage and an election form be mailed to your home. In the case of a divorce or ineligibility of a dependent child, you or your covered dependent must register your event online at www.advocatebenefits.com or by calling the Advocate Benefits Service Center at 800.775.4784.

You must elect continuing coverage within 60 days after an event that qualifies you or after you receive your election form, whichever is later. Your eligible family members have separate election rights. You have an additional 45-day period from the date you return your election form to pay the contributions necessary to avoid any gap in coverage. Any claims you file will not be paid until your contribution is received.

When Continuation of Coverage Ends
Continuation of coverage ends on the earliest of the following dates:

- You or your dependent becomes covered under another group medical or dental plan that does not contain an exclusion or limit for pre-existing conditions,
- You or your dependent becomes entitled to Medicare (except for end-stage renal disease),
- You don’t pay the initial or monthly premium within the required time frame,
- The program ends, or
- The continuation of coverage period—18, 29 or 36 months—ends.

Continuation of Coverage Administrator
If you have any questions about your eligibility for continuation of coverage, or you do not receive coverage information within 14 days of your registered qualifying event, contact the Advocate Benefits Service Center at 800.775.4784.

Evidence of Creditable Coverage
When you lose coverage under the HMO (or lose continuation of coverage), you are entitled to a certificate that shows evidence of your prior medical coverage from Advocate.

The Plan Administrator will provide this certificate promptly if you or your eligible dependents lose coverage under the HMO, if you or your dependents lose continuing coverage or whenever you submit a written request within 24 months after either of those events.

The certificate identifies (in general):
- Who was covered under the HMO
- The period of coverage, and
- Any waiting periods.

This certificate is used to determine pre-existing condition exclusion periods under another medical plan because your period of coverage under the HMO will offset the exclusion period of the new plan.
If you leave the Advocate Companies and enroll in coverage under another medical plan, check with your new plan’s administrator to find out whether the plan has a pre-existing condition exclusion and whether you need to provide a certificate or other documentation of your medical coverage from Advocate.

Plan Administration
Advocate Health Care Network is the Sponsor of the Plan.

The Plan Administrator of the Plan is:

Advocate Health Care Network
3075 Highland Parkway, Suite 600
Downers Grove, Illinois 60515
630.572.9393

Advocate has engaged the services of a third-party administrator to assist with the administration of the Plan.

- The HMO Administrator is responsible for processing claims and rendering the final decision in all appeals for the HMO.

The Continuation Coverage Administrator is responsible for managing coverage for those associates (and/or their dependents) who elect continuation coverage under the HMO.

Humana is the HMO Administrator:

Humana Insurance Company
P.O. Box 14601
Lexington, KY 40512

Tri-Star Systems is the Continuation Coverage Administrator:

Attn: Continuation ER128
14323 South Outer 40 Rd.
Suite 200 South
Chesterfield, MO 63017-5734
800.727.0182
314.985.0276 (fax)
(Monday through Friday, 7 am to 5 pm)

The agent for service of legal process is:

Advocate Health Care Network
3075 Highland Parkway, Suite 600
Downers Grove, Illinois 60515
630.572.9393

Prudent Actions by Plan Fiduciaries
The HMO administrator is the fiduciary of the Plan and has a duty to fulfill its fiduciary responsibilities prudently and in the best interest of you and other participants and beneficiaries of the HMO.

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