

Finger Lakes Area School Health Plan

General Information

Cost Sharing Expenses

| Benefit Name                                                 | In Network | Out of Network | Limits and Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------|------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Deductible - Single                                          | \$1,800    | \$1,980        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Deductible - Family                                          | \$3,600    | \$3,960        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Deductible Aggregation - Single and Family                   |            |                | The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member. If the family deductible amount exceeds the out of pocket maximum per person cap, the individual cannot contribute more than the out of pocket maximum per person cap amount for the plan year.<br>Family                                                                                                                                                                                                                    |
| Coinsurance                                                  | 20%        | 40%            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Annual Out of Pocket Maximum - Single                        | \$3,600    | \$3,960        | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.                                                                                                                                                                                                                                                                                                                                                                                    |
| Annual Out of Pocket Maximum - Family                        | \$7,200    | \$7,920        | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.                                                                                                                                                                                                                                                                                                                                                                                    |
| Annual Out of Pocket Maximum - Per Person Cap                | \$6,650    | \$7,920        | The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family. |
| Annual Out of Pocket Maximum Aggregation - Single and Family |            |                | The entire Family Annual Out-of-Pocket Maximum must be met before family members receive covered services processed at 100% of the allowable amount for the remainder of the plan year. An individual member covered under a family plan may not exceed the Out-of-Pocket Maximum per person cap amount for that plan year, should the family Out-of-Pocket Maximum level exceed the Out-of-Pocket Maximum Per Person Cap.<br>Family                                                                                                                  |

Office Visit Cost Shares

| Benefit Name              | In Network                               | Out of Network                           | Limits and Additional Information |
|---------------------------|------------------------------------------|------------------------------------------|-----------------------------------|
| Cost Share - Primary Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Cost Share - Specialist   | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

## Plan Limits

| Benefit Name                               | In Network | Out of Network | Limits and Additional Information |
|--------------------------------------------|------------|----------------|-----------------------------------|
| Plan/Calendar Year                         |            |                | Calendar Year Benefits            |
| Diabetic Preauthorization and Step Therapy |            |                | Applies                           |

## Who is Covered

| Benefit Name              | In Network | Out of Network | Limits and Additional Information |
|---------------------------|------------|----------------|-----------------------------------|
| Domestic Partner Coverage |            |                | Not Covered                       |

## Inpatient Services

### Inpatient Facility

| Benefit Name                 | In Network                               | Out of Network                           | Limits and Additional Information                             |
|------------------------------|------------------------------------------|------------------------------------------|---------------------------------------------------------------|
| Inpatient Hospital Services  | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                               |
| Mental Health Care           | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                               |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                               |
| Skilled Nursing Facility     | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per contract year<br>Limits are combined INN and OON. |
| Physical Rehabilitation      | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON.     |
| Maternity Care               | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                               |

### Inpatient Professional Services

| Benefit Name               | In Network                                                   | Out of Network                                   | Limits and Additional Information                                                                                                                |
|----------------------------|--------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient Hospital Surgery | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible         |                                                                                                                                                  |
| Anesthesia                 | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to \$1,800 Deductible | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. |

## Outpatient Facility Services

### Outpatient Facility Services

| Benefit Name                                                   | In Network                               | Out of Network                           | Limits and Additional Information                                        |
|----------------------------------------------------------------|------------------------------------------|------------------------------------------|--------------------------------------------------------------------------|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Diagnostic X-ray                                               | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Diagnostic Laboratory and Pathology                            | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Radiation Therapy                                              | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Chemotherapy                                                   | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Infusion Therapy Outpatient                                    | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Cost share applies to licensed services and infusion therapy separately. |
| Dialysis                                                       | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                          |
| Mental Health Care                                             | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization                                         |
| Substance Use Care                                             | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization                                         |

## Home and Hospice Care

### Home Care

| Benefit Name          | In Network                               | Out of Network                           | Limits and Additional Information                                                                                                                                                                                                                             |
|-----------------------|------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Home Care             | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                               |
| Home Infusion Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care). |

### Hospice Care

| Benefit Name           | In Network                               | Out of Network                           | Limits and Additional Information |
|------------------------|------------------------------------------|------------------------------------------|-----------------------------------|
| Hospice Care Inpatient | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

## Outpatient and Office Professional Services

### Professional Services

| Benefit Name                        | In Network                                                   | Out of Network                           | Limits and Additional Information |
|-------------------------------------|--------------------------------------------------------------|------------------------------------------|-----------------------------------|
| Office Surgery                      | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Diagnostic X-ray                    | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Radiation Therapy                   | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Chemotherapy                        | PCP/Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

| Benefit Name                      | In Network                                                | Out of Network                           | Limits and Additional Information                                                                                                                                                                                                                               |
|-----------------------------------|-----------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Infusion Therapy Services         | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Cost share applies to licensed services and infusion therapy separately.                                                                                                                                                                                        |
| Dialysis                          | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                                 |
| Mental Health Care                | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                                 |
| Maternity Care                    | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                                 |
| Telehealth                        | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                                 |
| TeleMedicine Program              | PCP/Specialist - 0% Coinsurance<br>Subject to Deductible  | Not Covered                              | Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and, if applicable, Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions. |
| Chiropractic Care                 | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                                                                                                                                                                                                 |
| Allergy Testing                   | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests.                                                                                                                                                                                                |
| Allergy Treatment Including Serum | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums).                                                                                                                                                                                                      |
| Hearing Evaluations Routine       | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>Limits are combined INN and OON.                                                                                                                                                                                                        |

## Rehab and Habilitation

### Outpatient Facility

| Benefit Name                | In Network                               | Out of Network                           | Limits and Additional Information                                                                                                                                          |
|-----------------------------|------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical Rehabilitation     | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation       | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

### Outpatient Professional Services

| Benefit Name                | In Network                                                | Out of Network                           | Limits and Additional Information                                                                                                                                          |
|-----------------------------|-----------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical Rehabilitation     | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation       | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines\*

| Benefit Name                        | In Network                       | Out of Network                           | Limits and Additional Information |
|-------------------------------------|----------------------------------|------------------------------------------|-----------------------------------|
| Adult Physical Examination          | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | 1 Exam per calendar year          |
| Adult Immunizations                 | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | 0% Coinsurance                           |                                   |
| Routine GYN Visit                   | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Pre/Post-Natal Care                 | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Professional  | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Professional  | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |

### Preventive Facility Services Meeting Federal Guidelines\*

| Benefit Name                    | In Network      | Out of Network                           | Limits and Additional Information |
|---------------------------------|-----------------|------------------------------------------|-----------------------------------|
| Cervical Cytology Preventative  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Facility  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Facility  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Facility | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |

### Preventive services in addition to those required under Federal Guidelines - Professional

| Benefit Name                        | In Network                                                | Out of Network                           | Limits and Additional Information |
|-------------------------------------|-----------------------------------------------------------|------------------------------------------|-----------------------------------|
| Prostate Cancer Screening           | PCP/Specialist - Covered in Full                          | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Professional  | PCP/Specialist - Covered in Full                          | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Professional  | PCP/Specialist - Covered in Full                          | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Professional | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

Preventive services in addition to those required under Federal Guidelines - Facility

| Benefit Name                    | In Network                               | Out of Network                           | Limits and Additional Information |
|---------------------------------|------------------------------------------|------------------------------------------|-----------------------------------|
| Mammography Screening Facility  | Covered in Full                          | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Facility  | Covered in Full                          | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

Other Benefits

Additional Benefits

| Benefit Name                                           | In Network                                                | Out of Network                           | Limits and Additional Information                                                          |
|--------------------------------------------------------|-----------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------|
| Treatment of Diabetes Preventive                       | N/A                                                       | N/A                                      |                                                                                            |
| Treatment of Diabetes - Non-Insulin Drugs and Supplies | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Treatment of Diabetes - Insulin                        | PCP/Specialist - 0% Coinsurance                           | 40% Coinsurance<br>Subject to Deductible | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Diabetic Equipment                                     | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                            |
| Durable Medical Equipment (DME)                        | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                            |
| Medical Supplies                                       | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                                                                            |
| Acupuncture                                            | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 10 Visits per contract year                                                                |
| Private Duty Nursing                                   | PCP/Specialist - Not Covered                              | Not Covered                              | Not Covered                                                                                |

Diagnoses

| Benefit Name                                  | In Network                                        | Out of Network                           | Limits and Additional Information                                                                                                                                                                                                                       |
|-----------------------------------------------|---------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Covered<br>Subject to Deductible | Covered<br>Subject to \$1,800 Deductible | \$4,000 Reimbursement Per Plan Year<br>Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

Emergency Services

ER Facility

| Benefit Name                  | In Network                               | Out of Network                                   | Limits and Additional Information                                                                                                              |
|-------------------------------|------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Facility Emergency Room Visit | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to \$1,800 Deductible | Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. |

Transportation

| Benefit Name                                               | In Network                               | Out of Network                                   | Limits and Additional Information |
|------------------------------------------------------------|------------------------------------------|--------------------------------------------------|-----------------------------------|
| Prehospital Emergency and Transportation - Ground or Water | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to \$1,800 Deductible |                                   |

### Urgent Care

| Benefit Name                      | In Network                               | Out of Network                           | Limits and Additional Information |
|-----------------------------------|------------------------------------------|------------------------------------------|-----------------------------------|
| Urgent Care Center Facility Visit | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

## Total Health Management Programs

### Wellness Programs

| Benefit Name      | In Network | Out of Network | Limits and Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------|------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wellbeing Program |            |                | Members can earn up to \$500 per plan year in rewards that can be used to purchase gift cards, fitness tracking devices or various other health and wellness items. Rewards are earned by completing gamification-style activities, including health challenges and journeys, daily cards, healthy habit tracking, and \$25 can be earned for completing a Health Risk Assessment that motivates them to focus on their total health and wellbeing.<br>ThriveWell Rewards |
| Reward Amount     |            |                | Rewards 1 \$500 EE & Spouse w/ \$25 HRA                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## Ancillary Benefits

### Vision

| Benefit Name                  | In Network                               | Out of Network                           | Limits and Additional Information |
|-------------------------------|------------------------------------------|------------------------------------------|-----------------------------------|
| Pediatric Eye Exams - Routine | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per year                   |
| Pediatric Eyewear - Routine   | Not Covered                              | Not Covered                              | Not Covered                       |
| Adult Eye Exams - Routine     | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per year                   |
| Adult Eyewear - Routine       | Not Covered                              | Not Covered                              | Not Covered                       |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information                                                                                        |
|--------------|------------|----------------|--------------------------------------------------------------------------------------------------------------------------|
| Rx Plan      |            |                | \$5/\$35/\$70 Integrated Rx, \$0 Generics for Kids<br><br>Diabetic Medications-<br>20% Coinsurance subject to deductible |

### Rx Benefits

| Benefit Name                 | In Network | Out of Network | Limits and Additional Information |
|------------------------------|------------|----------------|-----------------------------------|
| Days Supply Per Retail Order | 30         |                |                                   |
| Days Supply Per Mail Order   | 90         |                |                                   |
| Copays Per Mail Order Supply | 2          |                |                                   |

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.