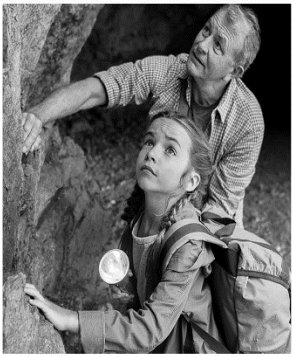
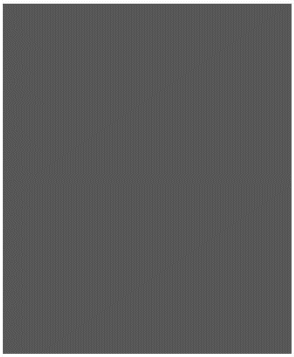
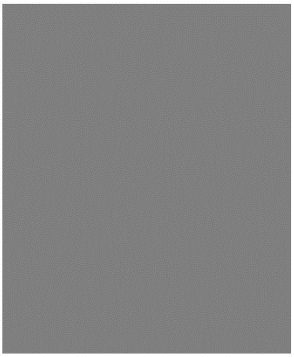
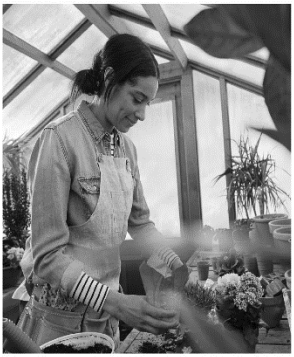
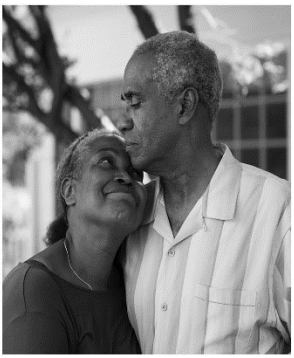
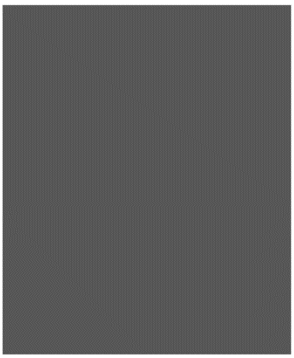
Administered by:

BlueCross BlueShield of Illinois


Your Health Care Benefits Program

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Noble Schools

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Table of Contents

INTRODUCTION

This Benefit Booklet describes the health care benefit program that the group named on the face page provides to its employees. In this Benefit Booklet, the group is referred to as "we, our, or "us;" employees as "you or your;" and, the group's health care benefit program as "the Health Care Plan."

Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

Your Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP) is an Independent Contractor, not an employee or agent of ours. We only provide administrative services for your health care benefit program. We are not your health care Provider.

The Definitions Section will explain the meaning of many of the terms used in this Benefit Booklet. All terms used in this Benefit Booklet, when defined in the Definitions Section, begin with a capital letter. Read your Benefit Booklet very carefully. Should you have any questions regarding its benefits, please contact customer service at the toll-free number on the back of your identification card. This Benefit Booklet replaces any that we may have previously provided to you under the Health Care Plan.

BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, it is necessary to read this entire Benefit Booklet to obtain a complete description of your benefits. It is important to remember that benefits will only be provided for services or supplies that have been ordered by your Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP), unless specified otherwise in this Benefit Booklet.

OVERALL PROGRAM DEDUCTIBLE

— Your Individual Coverage deductible*	$1,000 per calendar year
— Your Family Coverage deductible*	$2,000 per calendar year

PHYSICIAN BENEFITS

— Your cost for Covered Services (unless specified otherwise below)	None
— Your cost for Outpatient office visits	$20 per visit
— Your cost for Outpatient Specialist Physician visits	$40 per visit
— Your cost for Outpatient office visits for treatment of Mental Illness and Substance Use Disorder Treatment	$20 per visit
— Your cost for Outpatient Specialist Physician visits for treatment of Mental Illness and Substance Use Disorder Treatment	$20 per visit
— Your cost for Telehealth office visits	$20 per visit
— Your cost for Telehealth office visits for treatment of Mental Illness and Substance Use Disorder Treatment	$20 per visit
— Your cost for Telehealth Specialist Physician visits	$40 per visit

— Your cost for Telehealth Specialist Physician visits for treatment of Mental Illness and Substance Use Disorder Treatment	$20 per visit
— Your cost for Outpatient office visits for Periodic Health Examinations or Routine Pediatric Care	None
— Limit on Number of Chiropractic and Osteopathic Manipulation Visits	None
— Your cost for outpatient Rehabilitative Therapy Treatments	None
— Limit on Number of Outpatient Rehabilitative Therapy Treatments	60 treatments per calendar year
— Your cost for Outpatient office visits for preventive care services	None

HOSPITAL BENEFITS

— Your Deductible for Inpatient Covered Services (including Mental Illness)	10% of the Inpatient Hospital charge, after program deductible
— Your cost for Outpatient Surgery and Substance Use Disorder Treatment)	10% of the Inpatient Hospital charge, after program deductible
— Your cost for all other Outpatient Covered Services and Substance Use Disorder Treatment)	None

SUPPLEMENTAL BENEFITS

— Your cost for Covered Services	None

EMERGENCY CARE BENEFITS

— Your cost for an in-area emergency	$250 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)

— Your cost for an out-of-area emergency — $250 Emergency Room Copayment (waived if admitted to Hospital as an Inpatient immediately following emergency treatment)

— Your cost for emergency ambulance transportation — 10% of the Inpatient Hospital charge, after program deductible

SUBSTANCE USE DISORDER TREATMENT BENEFITS

— Your deductible for Inpatient Substance Use Disorder Treatment — 10% of the Inpatient Hospital Charges after program deductible

— Your cost for Outpatient office visits for Substance Use Disorder Treatment — $20 per visit

— Your cost for Outpatient Specialist Physician office visit for treatment of Substance Use Disorder Treatment — $20 per visit

Refer to the OTHER THINGS YOU SHOULD KNOW section of your Benefit Booklet for information regarding Covered Services expense limitation.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

Please refer to the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS section of your Benefit Booklet for additional information regarding how payment is determined.

— Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider participating in the **34-day supply** Prescription drug program:

  — Tier 1 Generic Drugs, and generic diabetic supplies, insulin and insulin syringes — $10 per Prescription

  — Tier 2 Preferred Brand-Name Drugs and preferred brand name diabetic supplies — $40 per Prescription

- Tier 3 Non-Preferred Brand-Name Drugs and preferred brand name diabetic supplies $60 per Prescription
- Self-injectable drugs other than Insulin and infertility drugs $50 per Prescription

— Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider not participating in the **34-day supply** Prescription drug program:

The appropriate Copayment(s) indicated above for drugs prescribed for emergency conditions.

— Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider participating in the **90-day supply** Prescription drug program:

- Tier 1 Generic Drugs, and generic diabetic supplies, insulin and insulin syringes $20 per Prescription
- Tier 2 Preferred Brand-Name Drugs and preferred brand name diabetic supplies $80 per Prescription
- Tier 3 Non-Preferred Brand-Name Drugs and preferred brand name diabetic supplies $120 per Prescription
- Self-injectable drugs other than insulin and infertility drugs $50 per Prescription

— Individual Out-of-Pocket Expenses Limit for prescription drugs and diabetic supplies $2,500 per calendar year

— Family Out-of-Pocket Expenses Limit for prescription drugs and diabetic supplies $5,000 per calendar year

— Your cost for Prescription drugs and diabetic supplies purchased from a Prescription Drug Provider not participating in the **90-day supply** Prescription drug program:

No benefits will be provided for drugs or diabetic supplies purchased from a Participating Prescription Drug Provider not participating in the 90-day supply program.

— Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

HEARING AID BENEFITS

Hearing Aid benefits for individuals under 18

— Benefit Period	24 months
— Benefit maximum	None
— Benefit payment level	100% of Provider's Charge
— Number of Hearing Aids, per ear, each benefit period	One

Hearing Aid benefits for individuals 18 or over

— Benefit Period	24 months
— Benefit maximum	2,500 per ear, per benefit period
— Benefit payment level	100% of Provider's Charge

LIMITING AGE FOR DEPENDENT CHILDREN 26*

*See Eligibility for age limit for certain children who are unmarried veterans.

YOUR OVERALL CALENDAR YEAR DEDUCTIBLE

If you have Individual Coverage, each calendar year you must satisfy the deductible amount(s) shown in the BENEFIT HIGHLIGHTS section of this Benefit Booklet before receiving benefits.

After you have incurred expenses for Covered Services in a calendar year which exceed this deductible amount, your benefits will begin. This deductible will be referred to as the program deductible.

If you have Family Coverage and your family has reached the program deductible amount shown in the BENEFIT HIGHLIGHTS section of this Benefit Booklet, it will not be necessary for anyone else in your family to meet a deductible in that calendar year. That is, for the remainder of that calendar year only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

The program deductible amount may change or increase upon renewal of the Group Policy as permitted by applicable law.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

ELIGIBILITY

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the benefits administered under the Health Care Plan.

Subject to the other terms and conditions of the Health Care Plan, the benefits described in this Benefit Booklet will be provided to persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for the benefits;
- Have received the Health Care Plan identification card from the Administrator;
- Live within the Health Care Plan's service area. (Contact the Claim Administrator's customer service at 1-800-892-2803 for information regarding service area.);
- Reside, live or work in the geographic network service area of a Participating IPA/Participating Medical Group for the Health Care Plan. You may call customer service at the number shown on the back of your identification card to determine if you are in the network service area or log on to the Administrator's website at *www.bcbsil.com.*

REPLACEMENT OF DISCONTINUED GROUP COVERAGE

If we initially offer the Health Care Plan as replacement benefits for a prior group health care benefit program sponsored by us, and;

- you are Totally Disabled on the effective date of this Health Care Plan;
- you were covered under the prior group health care benefit program sponsored by us immediately before the effective date of the Health Care Plan;

you will be considered eligible for benefits under the Health Care Plan.

Your Totally Disabled dependents will be considered eligible dependents under the Health Care Plan provided such dependents meet the description of an eligible family member as specified below under the heading Family Coverage.

Your dependent children who have reached the limiting age of the Health Care Plan will be considered eligible dependents under the Health Care Plan if they were covered under the prior group health care benefit program and, because of a handicapped condition, are incapable of self-sustaining employment and are dependent upon you or other care Providers for lifetime care and supervision.

If you are Totally Disabled, you will be entitled to all of the benefits of the Health Care Plan. The benefits of the Health Care Plan will be coordinated with benefits under the prior group health care benefit program. The prior group health care benefit program will be considered the primary coverage for all services rendered in connection with your disabling condition when no benefits are available under the Health Care Plan due to the absence of benefits in the Health Care Plan. The provisions of the Health Care Plan regarding Primary Care Physician referral remain in effect for such Totally Disabled persons.

APPLYING FOR BENEFITS

You may apply for benefits administered under the Health Care Plan for yourself and/or your spouse, party to a Civil Union, Domestic Partner and/or dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("Application(s)") to the Health Care Plan.

You can get the application form from the Employee Benefits Department. An application to add a newborn to Family Coverage is not necessary unless an additional contribution toward the cost of the newborn's benefits is required from you. However, you must notify the Employee Benefits Department within 31 days of the birth of a newborn child for benefits to continue beyond the 31 day period or you will have to wait until the Health Care Plan's next open enrollment period to enroll the child. The application(s) for benefits administered under the Health Care Plan may or may not be accepted.

You may enroll in or change benefits for yourself and/or your eligible spouse and/or dependents during one of the following enrollment periods. Your and/or your eligible spouse and/or dependents' effective date will be determined by us based upon the date they receive your application provided you are eligible and meet all enrollment requirements of the Health Care Plan.

We may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Person under the Health Care Plan.

Annual Open Enrollment Periods

We will designate annual open enrollment periods during which you may apply for or change benefits for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.

This section "Annual Open Enrollment Periods" may be changed by us, and/or applicable law, as appropriate.

Special Enrollment Periods

Special enrollment periods may also be designated during which you may apply for or change benefits for yourself and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents. You must apply for or request a change in benefits within 31 days from the date of a special enrollment event, except as otherwise provided below, in order to qualify for the changes described in this Special Enrollment Periods section.

You must provide acceptable proof of a qualifying event with your application. Special enrollment qualifying events are discussed in detail below. We will review this proof to verify your eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with your application will delay or prevent the processing of your application and enrollment in benefits administered under the Health Care Plan. Please call the Employee Benefits Department for examples of acceptable proof for the following qualifying events.

Special Enrollment Events:

a. You gain or lose a dependent or become a dependent through marriage or becoming a party to a Civil Union of a Domestic Partnership. New benefits for you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents will be effective on the date of the qualifying event, so long as you apply 31 days from the qualifying event date.

b. You gain or lose a dependent through birth, placement of a foster child, adoption or placement of adoption or court-ordered dependent coverage. New benefits for you and/or your eligible spouse, party to a Civil Union or Domestic Partner, and/or dependents will be effective on the date of the birth, placement of a foster child, adoption, or placement of adoption. However, the effective date for court-ordered eligible child coverage will be determined by the Plan in accordance with the provisions of the court-order.

c. You lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request benefits within 60 days of the loss of coverage.

d. You become eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or state child health plan. You must request benefits within 60 days of such eligibility.

This section "Special Enrollment Periods" may be changed by us, and/or applicable law, as appropriate.

Other Special Enrollment Events:

You must apply for or request a change in benefits within 31 days from the date of the below other special enrollment events in order to qualify for the changes described in this Other Special Enrollment Events section.

1. Loss of eligibility as a result of:
   - Legal separation or divorce, or dissolution of a Civil Union or a Domestic Partnership;
   - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under this Benefit Booklet);
   - Death of an Eligible Person
2. Termination of employment, reduction in the number of hours of employment.
3. Loss of coverage through an HMO in the individual market because you and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents no longer reside, live or work in the network service area.
4. Loss of coverage through an HMO, or other arrangement, in the group market because you and/or your eligible spouse, party to a Civil Union or Domestic Partner and/or dependents no longer reside, live or work in the network service area, and no other coverage is available to you

and/or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents.

5. You incur a claim that would meet or exceed a lifetime limit on all benefits.
6. Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
7. We cease to contribute towards your or your eligible spouse, party to a Civil Union, Domestic Partner and/or dependent's benefits (excluding COBRA continuation coverage) .
8. COBRA continuation coverage is exhausted.

A change in benefits resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application(s) including proof of such event and remittance of the appropriate contribution toward the cost of your benefits in accordance with the guidelines as established by the Health Care Plan. Your spouse, party to a Civil Union or Domestic Partner and other dependents are not eligible for a special enrollment period if the Group does not cover dependents.

This section "Other Special Enrollment Periods" may be changed by us, and/or applicable law, as appropriate.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

FAMILY COVERAGE

Under Family Coverage, your health care expenses and those of your enrolled spouse and your (and/or your spouse's) enrolled children who are under the limiting age specified in the BENEFIT HIGHLIGHTS section of this Benefit Booklet will be covered. All of the provisions of this Benefit Booklet that pertain to a spouse also apply to a party of a Civil Union. A Domestic Partner and his or her children who have not attained the limiting Age specified in the BENEFIT HIGHLIGHTS section of this Benefit Booklet may also be eligible dependents. All of the provisions of this Benefit Booklet that pertain to a spouse also apply to a Domestic Partner.

"Child(ren)" used hereafter in this Benefit Booklet, means a natural child(ren), a stepchild(ren), adopted child(ren), foster child(ren), a child(ren) who is in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- Live within the network service area of the Plan network of a Participating IPA/Participating Medical Group; and

- Have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- Have received a release or discharge other than a dishonorable discharge.

Benefits for children will end on the last day of the month in which the limiting age has been reached.

If you have Family Coverage, newborn children will be covered from the moment of birth. Please notify the Employee Benefits Department within 31 days of the birth so that the Health Care Plan records can be adjusted.

Children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, and foster children will be covered. In addition, if you have children for whom you are required by court order to provide health care coverage, those children will be covered.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care Providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age as long as they were covered prior to reaching the limiting age specified in the BENEFIT HIGHLIGHTS section.

This coverage does not include benefits for grandchildren (unless such children have been legally adopted or are under your legal guardianship).

MEDICARE ELIGIBLE ENROLLEE

A series of federal laws collectively referred to as the ``Medicare Secondary Payer" (MSP) laws regulate the manner in which we may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children. Reference to spouse under this section do not include a party to a Civil Union with the Eligible Person or Domestic Partners of the Eligible Person or their children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and our ("GHP") coverage, as well as certain other factors, including the size of our GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by us or whether the individual has "current employment status."

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

Please contact the Claim Administrator if you have any questions regarding the ESRD Primary Period or any other provisions of the MSP laws and their application to you, your spouse or your dependents.

Your MSP Responsibilities

In order to assist us in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Employee Benefits Department or the Claim Administrator regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact us or the Claim Administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR IDENTIFICATION CARD

You will receive an identification (ID) card. Your ID card contains your identification number, the name of the Participating IPA/Participating Medical Group that you have selected and the phone number to call in an emergency. Always carry your ID card with you. Do not let anyone who is not named in your benefits use your card to receive benefits. If you want additional cards or need to replace a lost or stolen card, contact the Claim Administrator's customer service or go to *www.bcbsil.com* and get a temporary card online.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO YOUR FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- The establishment of a Domestic Partnership.
- Becoming party to a Civil Union.
- Loss of eligibility for other health coverage for you or your dependent if:
    a. The other coverage was in effect when you were first eligible to enroll for benefits administered under the Health Care Plan;
    b. The other coverage is not terminating for cause (such as failure to pay any amount that you are required to contribute toward the cost of your coverage or mailing a fraudulent claim); and
    c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage

was the reason for declining enrollment for benefits administered under the Health Care Plan.

This includes, but is not limited to, loss of coverage due to:

a. Legal separation, divorce, dissolution of a Civil Union, cessation of dependent status, death of an employee, termination of employment, or reduction in number of hours of employment;
b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides; Reaching a lifetime limit on all benefits in another group health plan;
c. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
d. When Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss eligibility; or
e. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
f. Termination of employer contributions towards your or your dependent's other coverage.
g. Exhaustion of COBRA continuation coverage or state continuation coverage.

WHEN COVERAGE BEGINS

Your Family Coverage or the coverage for your additional dependent(s) will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

— Marriage.

— Birth, adoption or placement for adoption of a child.

— Obtaining legal guardianship of a child

— The establishment of a Domestic Partnership.

— Becoming party to a Civil Union.

— Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.

— Termination of employer contributions towards your or your dependent's other coverage.

— Exhaustion of COBRA continuation or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

— Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

— You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You can get the application form from us. However, an application to add a newborn to Family Coverage is not necessary unless an additional contribution toward the cost of the newborn's benefits is required from you. Please notify the Employee Benefits Department to determine if there is an additional cost and so that the Health Care Plan records can be adjusted.

LATE APPLICANTS

If you do not apply for Family Coverage or to add dependents within the allotted time, you will have to wait until your Group's annual open enrollment period to do so. Your Family Coverage or the coverage for your additional dependents will then be effective on the first day of the month following the open enrollment period. Benefits will not be provided for any treatment of an illness or injury to a newborn child unless you have Family Coverage. (Remember, you must add the newborn child within 31 days of the date of birth.)

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

You can apply to change from Family to Individual Coverage at any time. We will give you the application and tell you the date that the change will be effective. Any amount you are required to pay toward the cost of your benefits will be adjusted by us accordingly.

TERMINATION OF BENEFITS

You and your eligible spouse, party to a Civil Union, Domestic Partner and/or dependents' benefits will be terminated due to the following events and will end on the dates specified below:

a. The termination date specified by you, if you provide reasonable notice.

b. When we do not receive the full amount of payment that you are required to make toward the cost of your benefits or other charge or amount on time or when there is a bank draft failure toward such cost for your and/or your eligible spouse, party to a Civil Union, or Domestic Partner and/or dependents' benefits and the grace period, if any, has been exhausted.

c. You no longer live in the Health Care Plan's service area. (You must notify the Employee Benefits Department and the Claim Administrator within 31 days of a change in your address.)

d. Your benefits has been rescinded.

e. In the case of intentional fraud or material misrepresentation.

f. You no longer meet the previously stated description of an Eligible Person.

g. We terminate the Health Care Plan, or terminate it for all persons in a class to which you belong.

Termination of a Dependent's Benefits

If one of your dependents no longer meets the description of an eligible family member as described above under the heading "Family Coverage," his/her benefits will end as of the date the event occurs which makes him/her ineligible (for example, date of divorce). Benefits for children will end on the date previously described in this benefit section when they reach the limiting age as shown in the BENEFIT HIGHLIGHTS section of this Benefit Booklet.

Reinstatement

If you or your dependent's coverage has been terminated and you believe you have met or will meet the eligibility requirements of the Group Policy, please notify your Group and request reinstatement. For example, if you believe your Policy was terminated in error, please provide proof of eligibility to your Group.

WHO IS NOT ELIGIBLE

a. Incarcerated individuals, other than incarcerated individuals pending disposition of charges.

b. Individuals that do not live in the Plan's service area.

c. Individuals that do not meet the Plan's eligibility requirements or residency standards, as appropriate.

This section "WHO IS NOT ELIGIBLE" may be changed by us and/or applicable law, as appropriate.

EXTENSION OF BENEFITS IN CASE OF DISCONTINUANCE OF BENEFITS

If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for (and limited to) the Covered Services described in this Benefit Booklet which are related to the disability. Benefits will be provided when no coverage is available under the succeeding carrier's policy whether due to the absence of coverage in the policy. Benefits will be provided for a period of no more than 12 months from the date of termination. These benefits are subject to all of the terms and conditions of this Benefit Booklet including, but not limited to, the requirements regarding Primary Care Physician referral. It is your responsibility to notify the Employee Benefits Department and the Claim Administrator, and to provide, when requested, written documentation of your disability. This extension of benefits does not apply to the benefits provided in the following benefit section(s) of this Benefit Booklet:

- Outpatient Prescription Drug Program Benefits
- Hearing Aid Benefits

CONTINUATION COVERAGE RIGHTS UNDER COBRA NOTE:

We will provide you with a COBRA Continuation notice if you are eligible for COBRA and we are aware of a life event that qualifies you. Some employers, such as certain small groups and many religious organizations, may be exempt from providing COBRA in certain situations. Therefore, not all employees will always have a right to COBRA Continuation. If you believe that you have such a right and you have not received the COBRA notice, contact the Employee Benefits Office for questions and further information regarding your eligibility.

Introduction

You are receiving this notice because you have recently become covered under the Health Care Plan. This notice contains important information about the right to COBRA continuation coverage, which is a temporary extension of coverage under the Health Care Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Health Care Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Health Care Plan and under federal law, contact the Employee Benefits Department.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of the Health Care Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Health Care Plan is lost because of the qualifying event. Under the Health Care Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you may become a qualified beneficiary if you lose your coverage under the Health Care Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you may become a qualified beneficiary if you lose your coverage under the Health Care Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children may become qualified beneficiaries if they lose coverage under the Health Care Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Health Care Plan as a "dependent child."

Sometimes, an employer's filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event when a Health Care Plan covers you as a retiree. If a proceeding in bankruptcy is filed by us, and that bankruptcy results in the loss of coverage of any retired employee covered under the Health Care Plan, the retired employee may become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children would then also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Health Care Plan.

When Is COBRA Coverage Available?

We will offer COBRA continuation coverage to qualified beneficiaries only after a qualifying event has occurred.

You Must Give Notice of Some Qualifying Events

For certain qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Employee Benefits Department within 60 days after the qualifying event occurs. Contact your Employee Benefits Department, or its designated COBRA Administrator, for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Subject to timely notice, when required, once a qualifying event has occurred, we will offer COBRA continuation to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Health Care Plan is determined by the Social Security Administration to be disabled and you notify us in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact the Employee Benefits Department or its COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to us. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both),

or gets divorced or legally separated or if the dependent child stops being eligible under the Health Care Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning the Health Care Plan or your COBRA continuation coverage rights, should be addressed to the Employee Benefits Department, or to the Claim Administrator. Please note that some group health plans, such as certain small employer plans and certain religious organization plans, are exempted from certain federal laws. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Employee Benefits Department and the Claim Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employee Benefits Department or to the Claim Administrator.

Plan Contact Information

Contact your employer for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CONTINUATION OF COVERAGE
FOR PARTIES TO A CIVIL UNION

The purpose of this provision of your Benefit Booklet is to explain the options available for temporarily continuing your coverage after termination if you are covered under this Benefit Booklet as the party to a Civil Union with an Eligible Person or as the dependent child of a party to a Civil Union with an Eligible Person. Your continued coverage under this Benefit Booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation Coverage

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Benefit Booklet, the options available to a spouse or to a dependent child a s described in the CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws) provision of this Benefit Booklet are available to you. In addition, coverage similar to the options described in the **CONTINUATION COVERAGE RIGHTS UNDER COBRA** provision of this Benefit Booklet, will also be available to you.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA, or your continuation coverage options.

In addition to the events listed in the CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws) provision and CONTINUATION COVERAGE RIGHTS UNDER COBRA, if applicable, continuation coverage is available to you and your eligible spouse, party to a Civil Union, Domestic GB-16 HCSC NGF Blue Cross and Blue Shield of Illinois is a Division of Health Care Service Corporation 28 Partner and/or dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Benefit Booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

If you are a dependent who is a party to a Civil Union or their child and you lose coverage under this Benefit Booklet, the options available to a spouse or to a dependent child are described in the CONTINUATION COVERAGE

AFTER TERMINATION (Illinois State Laws) provision of this Benefit Booklet.

In addition to the events listed in the CONTINUATION COVERAGE AFTER TERMINATION (Illinois State Laws) provision, if applicable, continuation coverage is available to you and your eligible spouse, party to a Civil Union, and/or dependent children in the event you lose coverage because your Civil Union partnership with the Eligible Person terminates. Your Civil Union will terminate if your partnership no longer meets the criteria described in the definition of "Civil Union" in the DEFINITIONS section of this Benefit Booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

YOUR PRIMARY CARE PHYSICIAN

YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER IS AN INDEPENDENT CONTRACTOR, NOT AN EMPLOYEE OR AGENT OF OURS OR OF THE CLAIM ADMINISTRATOR. YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER RENDERS AND COORDINATES YOUR MEDICAL CARE. THE HEALTH CARE PLAN IS NOT YOUR HEALTH CARE PROVIDER.

As a participant in the Health Care Plan, a directory of Participating Individual Practice Associations (IPAs) and/or Participating Medical Groups are available to you. You can visit the website of the Claim Administrator, Blue Cross and Blue Shield, at *www.bcbsil.com* for a list of Participating IPAs and/or Participating Medical Groups or you can request a copy of the Provider directory by contacting the Claim Administrator's customer service at 1-800-892-2803.

At the time that you applied for benefits administered under the Health Care Plan, you selected a Participating Individual Practice Association (IPA) and a Primary Care Physician or a Participating Medical Group. If you enrolled in Family Coverage, then members of your family may select a different Participating IPA/Participating Medical Group. You must choose a Primary Care Physician for each of your family members from the selected Participating IPA/Participating Medical Group. In addition, female members also may choose a Woman's Principal Health Care Provider. You may also select a pediatrician as the Primary Care Physician for your dependent children from the same or a different Participating IPA/Participating Medical Group. A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Your Primary Care Physician is responsible for coordinating all of your health care needs. In the case of female members, your health care needs may be coordinated by your Primary Care Physician and/or your Woman's Principal Health Care Provider.

TO BE ELIGIBLE FOR THE BENEFITS ADMINISTERED UNDER THE HEALTH CARE PLAN AND DESCRIBED IN THIS BENEFIT BOOKLET, THE SERVICES THAT YOU RECEIVE MUST BE PROVIDED BY OR ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

To receive benefits for treatment from another Physician or Provider, you must be referred to that Physician or Provider by your Primary Care Physician or Woman's Principal Health Care Provider. That referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

If you have an illness or injury that needs ongoing treatment from another Physician or Provider, you may apply for a Standing Referral to that Physician or Provider from your Primary Care Physician or Woman's Principal Health Care Provider. Your Primary Care Physician or Woman's Principal Health Care Provider may authorize the Standing Referral which shall be effective for the period necessary to provide the referred services or up to a period of one year.

The only time that you can receive benefits for services not ordered by your Primary Care Physician or Woman's Principal Health Care Provider is when you are receiving emergency care or routine vision examinations. These benefits are explained in detail in the EMERGENCY CARE BENEFITS, HOSPITAL BENEFITS sections and, for routine vision examinations in the PHYSICIAN BENEFITS section of this Benefit Booklet. It is important that you understand the provisions of those sections.

PLEASE NOTE, BENEFITS WILL NOT BE PROVIDED FOR SERVICES OR SUPPLIES THAT ARE NOT LISTED AS COVERED SERVICES IN THIS BENEFIT BOOKLET, EVEN IF THEY HAVE BEEN ORDERED BY YOUR PRIMARY CARE PHYSICIAN OR WOMAN'S PRINCIPAL HEALTH CARE PROVIDER.

Changing Your Primary Care Physician or Woman's Principal Health Care Provider

You may change your choice of Primary Care Physician or Woman's Principal Health Care Provider to one of the other Physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group, your Primary Care Physician or Woman's Principal Health Care Provider or the Claim Administrator to obtain a list of Providers with whom your Primary Care Physician and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA/Participating Medical Group

You may change from your Participating IPA/Participating Medical Group to another Participating IPA/Participating Medical Group by calling the Claim Administrator at 1-800-892-2803.

The change will be effective the first day of the month following your call. However, if you are an Inpatient or in the third trimester of pregnancy at the time of your request, the change will not be effective until you are no longer an Inpatient or until your pregnancy is completed.

When necessary, Participating IPAs/Participating Medical Groups have the right to request your removal of from their enrollment. Their request cannot be based upon the type, amount or cost of services required by you. If the Health Care Plan determines that the Participating IPA/Participating Medical Group has sufficient cause and approves such a request, you will be offered enrollment in another Participating IPA or Participating Medical Group or enrollment in any other health care coverage then being provided under the Health Care Plan, subject to all its terms and conditions. The change will

be effective no later than the first day of the month following 45 days from the date the request is received

Selecting a Different Participating IPA/Participating Medical Group for Your Newborn

You may select a Participating IPA/Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA/Participating Medical Group/Woman's Principal Health Care Provider, if one has been selected, from the date of birth to the end of the month in which he/she is discharged from the Hospital. Your newborn may be added to the selected Participating IPA/Participating Medical Group on the first day of the month following discharge from the Hospital.

Changing Your Woman's Principal Health Care Provider

If your Woman's Principal Health Care Provider is within the same Participating IPA/Participating Medical Group as your Primary Care Physician and you wish to change to another Woman's Principal Health Care Provider within the same Participating IPA/Participating Medical Group, notify your Participating IPA/Participating Medical Group of your desire to change. Contact your Participating IPA/Participating Medical Group to obtain the specific procedures to follow.

If you wish to change to a Woman's Principal Health Care Provider who is not in the same Participating IPA/Participating Medical Group as your Primary Care Physician, you must contact the Claim Administrator at 1-800-892-2803.

After-Hours Care

Your Participating IPA/Participating Medical Group has systems in place to maintain a twenty-four (24) hour answering service and ensure that each Primary Care Physician or Woman's Principal Health Care Provider provides a twenty-four (24) hour answering arrangement and a twenty-four (24) hour on-call arrangement for all employees and family members enrolled with the Participating IPA/Participating Medical Group that can provide further instructions to you when your Primary Care Physician or Woman's Principal Health Care Provider is not available. In the case of an emergency, you will be instructed to dial 911.

Transition of Care Benefits

If you are a new Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits. You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective date. The Claim Administrator may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician’s agreement to contractual requirements and submission of a detailed treatment

plan. A written notice of the Plan's determination will be sent to you within 15 business days of receipt of your request.

If you are a current Enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy and your Primary Care Physician or Woman's Principal Health Care Provider leaves the Health Care Plan's network, you may request the option of Continuity of Care benefits as described in the Continuity of Care provision in the Other Things You Should Know section. You must submit a written request to the Claim Administrator for continuity of care benefits within 30 business days after receiving notification of your Primary Care Physician or Woman's Principal Health Care Provider's termination.

The Claim Administrator may authorize transition of care benefits for a period up to 90 days. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of a detailed treatment plan.

A written notice of the Claim Administrator's determination will be sent to you within 15 business days of receipt of your request.

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Authorization requirements of BCBSIL. Unless a Provider contracts directly with BCBSIL as a Participating Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements, except as described in the section "The BlueCard® Program" in the **OTHER THINGS YOU SHOULD KNOW** Section.

PHYSICIAN BENEFITS

This section of your Benefit Booklet explains what your benefits are when you receive care from a Physician.

Remember, to receive benefits for Covered Services, they must be performed by or ordered by your Primary Care Physician or Woman's Principal Health Care Provider. In addition, only services performed by Physicians are eligible for benefits unless another Provider, for example, a Dentist, is specifically mentioned in the description of the service.

Whenever we use "you" or "your" in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

The Health Care Plan includes benefits for the following Covered Services:

Surgery — when performed by a Physician, Dentist or Podiatrist or other Provider acting within the scope of his/her license.

However, benefits for oral Surgery are limited to the following services:

1. surgical removal of completely bony impacted teeth;
2. excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

— **Anesthesia** — if administered in connection with a covered surgical procedure by a Physician, Dentist or Podiatrist other than the operating surgeon or by a Certified Registered Nurse Anesthetist.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care, receptive and expressive language, learning, mobility, capacity for independent living or economic self-sufficiency or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 26 and have been diagnosed with an Autism Spectrum Disorder or a developmental disability.

For purposes of this provision only, the following definitions shall apply:

Autism Spectrum Disorder .....means a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

Developmental Disability .....means a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- It manifested before the age of 22;
- It is likely to continue indefinitely; and
- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

— **An assistant surgeon** — that is, a Physician, Dentist or Podiatrist who actively assists the operating surgeon in the performance of a covered surgical procedure.

— **Additional Surgical Opinion** — following a recommendation for elective Surgery. Your benefits will be limited to one consultation and any related Diagnostic Service by a Physician.

— **Surgery for morbid obesity** — including, but not limited to, bariatric Surgery.

Medical Care

Benefits will be provided for Medical Care rendered to you:

— when you are an Inpatient in a Hospital, Skilled Nursing Facility or a Residential Treatment Center;

— when you are a patient in a Partial Hospitalization Treatment Program or Home Health Care Program; or

— on an Outpatient basis in your Physician's office or your home.

Medical Care visits will only be covered for as long as your stay in a particular facility or program is eligible for benefits (as specified in the HOSPITAL BENEFITS section of this Benefit Booklet).

Benefits for the treatment of Mental Illness is also a benefit under your Medical Care benefits. In addition to a Physician, Mental Illness rendered under the supervision of a Physician by a clinical social worker or other mental health professional is covered.

Consultations — that is, examination and/or treatment by a Physician to obtain his/her advice in the diagnosis or treatment of a condition which requires special skill or knowledge.

Mammograms — Benefits will be provided for routine mammograms for all women age 35 and older. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered medically necessary or as often as your Primary Care Physician or Woman's Principal Health Care Provider finds necessary.

If a routine mammogram reveals heterogeneous or dense breast tissue, or when determined to be medically necessary by your Primary Care Physician, Women's Principal Health Care Provider, Advanced Practice Nurse Physician, Advanced Practice Nurse, or Physician Assistant, benefits will be provided for a comprehensive ultrasound screening or magnetic resonance imaging ("MRI") screening of an entire breast or breasts.

Benefits for Diagnostic Mammograms will be provided for women when determined to be medically necessary by your Primary Care Physician, Woman's Principal Health Care Provider, Advanced Practice Nurse, or Physician Assistant. Benefits for mammogram will be provided at 100% of the Provider's Charge, whether or not you have met your program deductible, and will not be subject to any benefit period maximum or lifetime maximum.

Diagnostic Mammograms....means a mammogram obtained using Diagnostic Mammography.

Diagnostic Mammography....means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality in the breast.

Breast Cancer Pain Medication — Benefits will be provided for all medically necessary pain medication and pain therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically-based and includes reasonably defined goals, including, but not limited to stabilizing or

reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Breast Reduction Surgery — Benefits will be provided for Medically Necessary breast reduction surgery.

Fibrocystic Breast Condition — Benefits will be provided for Covered Services related to fibrocystic breast condition.

Hormone Therapy to Treat Menopause — Benefits will be provided for Medically Necessary hormone therapy to treat menopause that has been induced by a hysterectomy.

Pancreatic Cancer Screening — Benefits will be provided for Medically Necessary pancreatic cancer screenings**.**

Outpatient Periodic Health Examinations — including the taking of your medical history, physical examination and any diagnostic tests necessary because of your age, sex, medical history or physical condition. You are eligible for these examinations as often as your Primary Care Physician or Woman's Principal Health Care Provider, following generally accepted medical practice, finds necessary.

Covered Services include, but are not limited to:

- clinical breast examinations;
- routine cervical smears or Pap smears;
- routine prostate-specific antigen tests and digital rectal examinations;
- colorectal cancer screening — as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology; and
- ovarian cancer screening — using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

Benefits will also be provided for pre-marital examinations that are required by state or federal law. Benefits are not available for examinations done for insurance or employment screening purposes.

Routine Pediatric Care — that is, the routine health care of infants and children including examinations, tests, immunizations and diet regulation. Children are eligible for benefits for these services as often as is felt necessary by their Primary Care Physician.

Benefits will also be provided for pre-school or school examinations that are required by state or federal law. Benefits are not available for recreational/camp physicals or sports physicals. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of this Benefit Booklet.

Diagnostic Services — these services will be covered when rendered by a Dentist or Podiatrist, in addition to a Physician.

Diagnostic Colonoscopies — Benefits will be provided for diagnostic colonoscopies, when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant.

Benefits for diagnostic colonoscopies will be provided at no charge after your program Deductible has been met.

Biomarker Testing — Benefits will be provided for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

Vitamin D Testing — Benefits will be provided for Vitamin D Testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

A1C Testing — Benefits will be provided for A1C testing for prediabetes, type I diabetes, and type II diabetes, in accordance with pre-diabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention.

Allergy Testing and Treatment

Injected Medicines — that is, drugs that cannot be self-administered and which must be administered by injection. Benefits will be provided for the drugs and the administration of the injection. This includes routine immunizations and injections that you may need for traveling. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of this Benefit Booklet.

In addition, benefits will be provided for a human papillomavirus (HPV) vaccine and a shingles vaccine approved by the federal Food and Drug Administration.

Amino Acid-Based Elemental Formulas — Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome.

Electroconvulsive Therapy — including benefits for anesthesia administered with the electroconvulsive therapy if the anesthesia is administered by a Physician other than the one administering the therapy.

Radiation Therapy — that is, the use of ionizing radiation in the treatment of a medical illness or condition.

Massage Therapy — that is, massage to treat muscle pain or dysfunction.

Chemotherapy —Benefits will be provided for the non-self-intravenous Cancer Medications that are used to kill or slow the growth of cancerous cells.

Cancer Medications — Benefits will be provided for orally administered cancer medications, that are used to kill or slow the growth of cancerous cells. Your deductible, Copayment Amount or Coinsurance Amount will not apply to orally administered cancer medications when such services are received from your Primary Care Physician or Woman's Principal Health Care Provider.

Comprehensive Cancer Testing — Benefits will be provided for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels. This plan also provides benefits for Medically Necessary testing of blood or constitutional tissue for cancer predisposition testing as determined by a licensed Physician.

Outpatient Rehabilitative Therapy — including, but not limited to, Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Primary Care Physician or Woman's Principal Health Care Provider, must be either (a) limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered, except as specifically provided for under the **Autism Spectrum Disorder(s)** provision and the plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (b) prescribed as preventive or Maintenance Physical Therapy for you if affected by multiple sclerosis, subject to the benefit maximum. Benefits for Outpatient rehabilitative therapy are limited to a combined maximum of 60 treatments per calendar year.

Blood Glucose Monitors for Treatment of Diabetes — Benefits are available for medically necessary blood glucose monitors (including non-invasive monitors and monitors for blind) for which a Physician has written an order.

Tobacco Use Screening and Smoking Cessation Counseling Services

Tobacco Use Cessation Drugs

Cardiac Rehabilitation Services — Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

Early Treatment of Serious Mental Illness — Benefits will be provided to treat a serious mental illness in a child or young adult under age 26, for the following bundled, evidenced-based treatments:

— First Episode Psychosis Treatment– benefits for coordinated specialty care for first episode psychosis treatment will be covered when provided by FIRST.IL Providers.

— Assertive Community Treatment (ACT) – benefits for ACT will be covered when provided by DHS-Certified Providers.

— Community Support Team Treatment (CST) – benefits for CST will be covered when provided by DHS-Certified Providers.

Autism Spectrum Disorder(s) — Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Physician or Woman's Principal Health Care Provider who has determined that such care is medically necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) and when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

— psychiatric care, including Diagnostic Services;

— psychological assessment and treatment;

— habilitative or rehabilitative treatment;

— therapeutic care, including behavioral Occupational Therapy, Physical Therapy and Speech Therapy that provide treatment in the following areas:

a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Benefit Highlights. Please review the Outpatient Rehabilitative Therapy section of this Benefit Booklet.

Habilitative Services — Your benefits for Habilitative Services are the same as your benefits for any other condition if all of the following conditions are met:

1. a Physician has diagnosed the Congenital, Genetic or Early Acquired Disorder; and
2. treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker or Psychologist upon the referral of your Primary Care Physician or Woman's Principal Health Care Provider; and
3. treatment must be medically necessary and therapeutic and not Investigational.

Outpatient Respiratory Therapy — Benefits will be provided for outpatient repiratory therapy when rendered for the treatment of an illness or injury by or under the supervision of a qualified respiratory therapist.

Epinephrine Injectors — Unless otherwise provided for in this Benefit Booklet, benefits for Medically Necessary epinephrine injectors are available under this benefit section.

Long-term Antibiotic Therapy — Benefits will be provided for Long-term Antibiotic Therapy, including necessary office visits and ongoing testing, for a person with a Tick-Borne Disease when determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.
An experimental drug will be covered as a Long-term Antibiotic Therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

Gender Reassignment and Related Supplies and Services — Benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.

Telehealth and Telemedicine Services — Benefits will be provided for Telehealth and Telemedicine Services as described in the BENEFIT HIGHLIGHTS section of this Benefit Booklet.

Chiropractic and Osteopathic Manipulation — Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Hearing Screening — Benefits will be provided when done to determine the need for hearing correction.

Diabetes Self-Management Training and Education —Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1C level within the range identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Routine Vision Examinations — benefits will be provided for a routine vision examination, limited to one visit per a 12 month period, without a referral from your Primary Care Physician or Woman's Principal Health Care Provider for vision examinations done to determine the need for vision correction including determination of the nature and degree of refractive errors of the eyes.

The examination must be rendered by an Optometrist or Physician who has an agreement with the Plan, directly or indirectly, to provide routine vision examinations to you. Routine vision examinations do not include medical or surgical treatment of eye diseases or injuries.

Benefits will not be provided for eyeglasses or contact lenses, unless otherwise specified in this Benefit Booklet.

Preventive Care Services

In addition to the benefits otherwise provided in this Benefit Booklet, (and notwithstanding anything in your Benefit Booklet to the contrary), the following preventive care services will be considered Covered Services when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and will not be subject to any deductible, Coinsurance, Copayment or benefit dollar maximums, if any, as shown elsewhere in this Benefit Booklet, such as in the Benefit Highlights section:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. with respect to women, such additional preventive care and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current

The preventive care services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's website at *www.bcbsil.com* or contact customer service at the toll-free number on your identification card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques to determine benefits.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment for the office visit including the preventive health service.

Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
2. Unhealthy alcohol and drug use screening and counseling
3. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive multicomponent behavioral interventions.
4. Aspirin use for men and women for prevention of cardiovascular disease for certain ages
5. Blood pressure screening
6. Cholesterol screening for adults of certain ages or at higher risk
7. Colorectal cancer screening for adults over age 45
8. Depression screening
9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease
10. HIV screening for all adults at higher risk
11. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition, including baseline and monitoring services
12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - COVID-19
13. Obesity screening and counseling
14. Sexually transmitted infections (STI) counseling
15. Tobacco use screening and cessation interventions for Tobacco Users
16. Syphilis screening for adults at higher risk
17. Exercise intervention to prevent falls in adults age 65 years and older who are at increased risk for falls

18. Hepatitis C virus (HCV) screening infection in adults aged 18 to 79 years
19. Hepatitis B virus screening for persons at high risk for infection
20. Counseling children, adolescents, and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
21. Lung cancer screening in adults 50 and older who have a 20-pack year smoking history and currently smoke or have quit within the past 15 years
22. Screening for high blood pressure in adults age 18 years or older
23. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese
24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at a higher risk of tuberculosis
26. Whole body skin examination for lesions suspicious for skin cancer

Preventive Care Services for Women (including pregnant women and others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. Perinatal depression screening and counseling
3. BRCA counseling about genetic testing for women at higher risk and if recommended by a Provider after counseling, and genetic testing
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Electric breast pumps are limited to one per calendar year
6. Cervical cancer screening
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling
9. Domestic and interpersonal violence screening and counseling for all women
10. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
11. Diabetes screening after pregnancy

12. Female and male condoms
13. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
14. Gonorrhea screening for all women
15. Hepatitis B screening for pregnant women at their first prenatal visit
16. HIV screening and counseling for all women
17. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
18. Osteoporosis screening for women over age 65 and younger women with risk factors
19. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
20. Tobacco use screening and interventions for all women, and expanded counseling for pregnant Tobacco Users
21. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
22. Sexually transmitted infections (STI) counseling
23. Syphilis screening for all pregnant women or other women at increased risk
24. Well-woman visits to obtain recommended preventive services
25. Urinary incontinence screening
26. Breast cancer mammography screenings, including breast tomosynthesis and, if determined to be Medically Necessary, a screening MRI and comprehensive ultrasound
27. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence and device removal
28. Aspirin use for pregnant women to prevent preeclampsia
29. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
30. Behavioral counseling to promote healthy weight gain during pregnancy
31. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older

Preventive Care Services for Children (or others as specified):

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Depression screening for adolescents

7. Critical congenital heart defect screening for newborns
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 7-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns, children and adolescents
15. Height, weight and body mass index measurements
16. Hematocrit or hemoglobin screening
17. Hemoglobinopathies or sickle cell screening for all newborns
18. HIV screening for adolescents at higher risk
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus
    - Influenza (Flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - Haemophilus influenzae type b
    - Rotavirus
    - Inactivated Poliovirus Vaccine
    - Diphtheria, tetanus & acellular pertussin
    - COVID-19
20. Lead screening for children at risk for exposure
21. Autism screening
22. Medical history for all children throughout development
23. Obesity screening and counseling
24. Oral health risk assessment for younger children up to six years old
25. Phenylketonuria (PKU) screening for newborns
26. Sexually transmitted infections (STI) prevention and counseling for adolescents

27. Tuberculin testing for children at higher risk of tuberculosis
28. Vision screening for children and adolescents
29. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
30. Newborn blood screening
31. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision
32. Whole body skin examination for lesions suspicious for skin cancer

The FDA approved contraceptive drugs and devices currently covered under this benefit provision are listed on the Contraceptive Coverage List. This list is available on our website at www.bcbsil.com and by contacting customer service at the toll-free number on the back of your identification card.

Drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a Non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, deductibles, or dollar maximums, if applicable.

Benefits are not available under this benefit provision for Contraceptive drugs and devices not listed on the *Contraceptive Coverage List*. You may, however, have coverage under other sections of this Benefit Booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximum if any, as shown elsewhere in this Benefit Booklet, such as in the Benefit Highlight section. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Pediatric care, women's preventive care and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums, if any, as shown elsewhere in this Benefit Booklet, such as in the Benefit Highlights section.

Dental Accident Care — that is, dental services rendered by a Dentist or Physician which are required as the result of an accidental injury. However, these services are covered only if the injury is to sound natural teeth. A sound natural tooth is any tooth that has an intact root or is part of a permanent bridge.

Family Planning Services — including family planning counseling, prescribing of contraceptive drugs and fitting of contraceptive devices and voluntary sterilization. See Outpatient Contraceptive Services below for additional benefits.

Benefits are not available under this benefit section for the actual contraceptive drugs.

Benefits for sterilization procedures will not be subject to any deductible, Coinsurance and/or Copayment when such services are ordered from your Primary Care Physician or Woman's Principal Health Care Provider.

Outpatient Contraceptive Services — Benefits will be provided for Outpatient contraceptive services. Outpatient contraceptive services includes, but is not limited to consultations, patient examinations, counseling on contraception, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. In addition, benefits will be provided for medically necessary contraceptive devices, injections and implants approved by the federal Food and Drug Administration, as prescribed by your Physician, follow-up services related to drugs, devices, products, procedures, including but not limited to, management of side effects, counseling for continued adherence and device insertion and removal.

Benefits for Outpatient contraceptive services will not be subject to any deductible, Coinsurance and/or Copayment when such services are ordered from your Primary Care Physician or Woman's Principal Health Care Provider.

Contraceptive Drugs Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* and will not be subject to any deductible, Coinsurance and/or Copayment when received from a Participating Prescription Drug Provider.

In addition, you may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products.

Benefits will also be provided for dispensed contraceptive drugs and products when purchased through the Home Delivery Prescription Drug Program. The Home Delivery Prescription Drug Program provides delivery of covered drugs directly to your home address. Benefits under the Home Delivery Program are limited to certain contraceptive drugs and products.

Benefits will not be provided for any other Outpatient drugs and/or medicines under this benefit provision or any other benefit section of this Certificate, except as otherwise specified.

If you are unsure whether a Pharmacy is a Participating Pharmacy or for additional information about the Home Delivery Prescription Drug Program, you may access Blue Cross and Blue Shield's website at www.bcbsil.com or call the customer service toll-free number on your identification card.

You, your prescribing health care Provider (your "prescriber") or your authorized representative, can ask for the *Drug List* or the *Contraceptive Coverage* exception if your drug is not on (or is being removed from) the *Drug List* or the Contraceptive *Coverage List* or the drug required as part of step therapy or dispensing limit has been found to be (or is likely to be) not right for you or does not work as well in treating your condition. To request this exception, you, your prescriber or authorized representative can call the

number on the back of your identification card to ask for a review. Blue Cross and Blue Shield will let you, your prescriber or authorized representative know the coverage decision within 72 hours after they receive your request. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber or authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial.

If you have a health condition that may jeopardize your life, health or keep you from regaining function or your current drug therapy uses a non-covered drug, you, your prescriber or your authorized representative may be able to ask for an expedited review process. Blue Cross and Blue Shield will let you, your prescriber or your authorized representative know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield will let you, your prescriber or your authorized representative know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

Bone Mass Measurement and Osteoporosis — Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment — Benefits will be provided for routine patient care in conjunction with Experimental/Investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Benefit Booklet if not provided in connection with an Approved Clinical Trial program. You and your Physician are encouraged to call the Claim Administrator's customer service at the toll-free number on the back of your identification card in advance to obtain information about whether a particular clinical trial is qualified.

Approved Clinical Trials — Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial or other Life Threatening Disease or Condition and is recognized under state and/or federal law.

HIV Screening and Counseling — Benefits will be provided for HIV screening and counseling and pre-natal HIV testing ordered by your Primary Care Physician or Women's Principal Health Care Provider, including but not limited to orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Unless otherwise stated, benefits will be provided as described in the Preventive Care Services provision of this section of your Benefit Booklet.

Fertility Treatment

Benefits will be provided for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means a disease, condition, or status characterized by 1) the inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility), 2) a person's inability to reproduce either as a single individual or with a partner without medical intervention, or 3) a licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Unprotected sexual intercourse means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate Fertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless. Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per calendar year. These benefits include other Medically Necessary services until you or your surrogate is discharged to regular obstetrical.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval.

Benefits under this Infertility Treatment provision will not be provided for the following:

1. Services or supplies rendered to a surrogate, after eggs, sperm or embryos have been transferred into the surrogate, non-medical expenses you incur to contract with the surrogate, and any other services rendered to a surrogate that are not directly related to treatment of your infertility.
2. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note that benefits

may be provided for fertility preservation as set forth in the Fertility Preservation provision of this Benefit Booklet.

3. Non-medical costs of an egg or sperm donor.
4. Travel costs for travel within 100 miles of the Enrollee's home or which is not medically necessary or which is not required by the Plan.
5. Fertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology.
6. Fertility treatment rendered to your dependents under the age of 18.
7. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "Infertility" as stated above.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Fertility Preservation Services

Benefits will be provided for medically necessary Standard Fertility Preservation Services when a necessary medical treatment May Directly or Indirectly Cause Iatrogenic Infertility to a member.

Temporomandibular Joint Dysfunction and Related Disorders

Benefits for all of the Covered Services previously described in this Benefit Booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Port-Wine Stain Treatment

Benefits for all of the Covered Services previously described under this Benefit Booklet are available for the treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber Syndrome. This benefit does not apply to Port-Wine Stain Treatment, solely for cosmetic reasons.

Mental Illness and Substance Use Disorder Treatment

Benefits will be provided for medically necessary Mental Illness and Substance Use Disorder Treatment when referred by your Primary Care Physician or Woman's Principal Health Care Provider. Benefits for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder includes pregnancy and postpartum periods.

Mastectomy Related Services

Benefits will be provided for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) post mastectomy care for Inpatient treatment for a length of time determined by the attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation, and a follow-up Physician office visit or in-home nurse visit within forty-eight (48) hours after discharge; and 4) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; 5) the removal of breast implants when the removal of the implants is a medically necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury are not considered cosmetic Surgery.

Early Treatment of a Serious Mental Illness

Benefits will be provided to treat a serious mental illness in a child or young adult under age 26, for the following bundled, evidenced-based treatments:

1. **First Episode Psychosis Treatment–** benefits for coordinated specialty care for first episode psychosis treatment will be covered when provided by FIRST.IL Providers.
2. **Assertive Community Treatment (ACT) –** benefits for ACT will be covered when provided by DHS Certified Providers.
3. **Community Support Team Treatment (CST) –** benefits for CST will be covered when provided by DHS-Certified Providers.

In addition to the **DEFINITIONS** in this Benefit Booklet, the following definitions are applicable to this provision:

DHS-Certified Provider……means a provider certified to provide ACT and CST by the Illinois Department of Human Services' Division of Mental Health and approved to provide ACT and CST by the Illinois Department of Healthcare and Family Services.

FIRST IL Provider……means a provider contracted with the Illinois Department of Human Services' Division of Health to deliver coordinated specialty care for first episode psychosis treatment.

Maternity Services

Your benefits for maternity services are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will be provided for delivery charges and for any of the previously described Covered Services when rendered in connection with pregnancy. For Family Coverage benefits will be provided for any treatment of an illness, injury, congenital defect, birth abnormality or a premature birth from

the moment of the birth up to the first 31-60 days. You must notify the employee benefits department within 31 days of the birth so that the Health Care Plan records can be adjusted to add the newborn child to your Family Coverage. Any amount you are required to contribute toward the cost of your benefits will be adjusted by us accordingly.

Benefits will be provided for the mother and the newborn for a minimum of:

1. 48 hours of Inpatient care following a vaginal delivery, or
2. 96 hours of Inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of Hospital Inpatient stay related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetrics and Gynecology or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Your Provider will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there are benefits and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Health Care Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

Other Reproductive Services — Your coverage includes benefits for abortion care. Benefits for abortion care are the same as your benefits for any other condition under this PHYSICIAN BENEFITS Section.

URGENT CARE

This benefit provides medically necessary Outpatient care if you are outside the Health Care Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Medical Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such urgent care, you should contact the Claim Administrator at 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for urgent care.

Your Cost for Urgent Care Treatment

100% of the Provider's Charge will be paid for urgent care received outside of the Health Care Plan's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Your Cost for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Health Care Plan's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable.

YOUR COST FOR PHYSICIAN SERVICES

Benefits for all Outpatient office visits are subject to a Copayment of $20 per visit, unless otherwise specified in this Benefit Booklet, and then will be paid in full

The following Covered Services of this benefit section are not subject to the office visit Copayment described above and benefits will be paid in full, with no cost to you:

— Surgery;

— Chiropractic and osteopathic manipulation;

— Outpatient periodic health examinations;

— Preventive care services;

— Maternity services after the first pre-natal visit; and

— Diagnostic Colonoscopies.

Benefits for Outpatient visits to a Specialist Physician's office are subject to a Copayment of $40 per visit and then will be paid in full.

The Covered Services of this benefit section will be paid as described above when such services are received from a:

— Physician

— Physician Assistant

— Certified Nurse Midwife

— Certified Nurse Practitioner

— Certified Registered Nurse Anesthetist

— Certified Clinical Nurse Specialist
— Marriage and Family Therapist

HOSPITAL BENEFITS

This section of your Benefit Booklet explains what your benefits are when you receive care in a Hospital or other eligible health care facility. Benefits are only available for services rendered by a Hospital unless another Provider is specifically mentioned in the description of the service.

Remember, to receive benefits for Covered Services, they must be ordered or approved by your Primary Care Physician or Woman's Principal Health Care Provider.

Whenever we use “you” or “your” in describing your benefits, we mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Inpatient Benefits

You are entitled to benefits for the following services when you are an Inpatient in a Hospital or Skilled Nursing Facility:

1. **Bed, board and general nursing care** when you are in:
   - — a semi-private room or a private room - must be ordered by your Primary Care Physician or Woman's Principal Health Care Provider.
   - — an intensive care unit.
2. **Ancillary services** (such as operating rooms, drugs, surgical dressings and lab work).
3. **Rehabilitative Therapy** (including, but not limited to Physical, Occupational and Speech Therapy).

You are also entitled to Inpatient benefits for the diagnosis and/or treatment of Mental Illness when you are in a Residential Treatment Center.

No benefits will be provided for admissions to a Skilled Nursing Facility or a Residential Treatment Center which are for Custodial Care Service or because care in the home is not available or the home is unsuitable for such care.

Number of Inpatient Days

There are no limits on the number of days available to you for Inpatient care in a Hospital or other eligible facility.

Outpatient Benefits

You are entitled to benefits for the following services when you receive them from a Hospital, or other specified Provider, on an Outpatient basis:

1. **Surgery** — when performed in a Hospital or Ambulatory Surgical Facility. Benefits for Surgery also include Surgery for morbid obesity (including, but not limited to bariatric Surgery).

2. **Diagnostic Services** — that is, tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury.
3. **Radiation Therapy** — that is, the use of ionizing radiation in the treatment of a medical illness or condition.
4. **Chemotherapy** — that is, the treatment of malignancies with drugs.
5. **Electroconvulsive Therapy**
6. **Renal Dialysis Treatments and Continuous Ambulatory Peritoneal Dialysis Treatment** — when received in a Hospital or a Dialysis Facility. Benefits for treatment in your home are available if you are homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and are rendered under the supervision of a Hospital or Dialysis Facility health care professional.

Special Programs

You are entitled to benefits for the special programs listed below. The services covered under these programs are the same as those that are available when you are an Inpatient in a Hospital. These programs are as follows:

1. **Coordinated Home Care Program**
2. **Pre-Admission Testing** — This is a program in which preoperative tests are given to you as an Outpatient in a Hospital to prepare you for Surgery that you are scheduled to have as an Inpatient.
3. **Partial Hospitalization Treatment Program** — This is a therapeutic treatment program in a Hospital for patients with Mental Illness.
4. **Intensive Outpatient Treatment Program** — This is a Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorders or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorders. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by your Participating IPA or Participating Medical Group as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Approved Clinical Trials — Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial or other Life Threatening Disease or Condition and is recognized under state and/or federal law.

Autism Spectrum Disorder(s) — Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) your Primary Care Physician or Woman's Principal Health Care Provider who has determined that such care is medically necessary, or (b) a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder(s) when the care is determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider:

- psychiatric care, including Diagnostic Services;
- psychological assessment and treatment;
- habilitative or rehabilitative treatment;
- therapeutic care, including behavioral Occupational, Physical and Speech Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Habilitative Services — Your benefits for Habilitative Services are the same as your benefits for any other condition if all of the following conditions are met:

1. a Physician has diagnosed the Congenital, Genetic or Early Acquired Disorder; and
2. treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker or Psychologist upon the referral of your Primary Care Physician or Woman's Principal Health Care Provider; and
3. treatment must be medically necessary and therapeutic and not Investigational.

Gender Reassignment and Related Services — Your benefits for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.

Surgical Implants

The Health Care Plan includes benefits for surgically implanted internal and permanent devices. Examples of these devices are internal cardiac valves, internal pacemakers, mandibular reconstruction devices, bone screws and vitallium heads for joint reconstruction.

Maternity Services

Your benefits for services rendered in connection with pregnancy are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. In addition to all of the previously described Covered Services, routine Inpatient nursery charges for the newborn child are covered, even under Individual Coverage. (If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, that care will be covered from the moment of birth up to the first 31 days, thereafter, you must add the newborn child to your Family Coverage. Any amount you are required to contribute toward the cost of your benefits will be adjusted by us accordingly.

Benefits will be provided for the mother and the newborn for a minimum of:

1. 48 hours of Inpatient care following a vaginal delivery, or
2. 96 hours of Inpatient care following a delivery by caesarean section,

except as may be indicated by the following: A shorter length of Hospital Inpatient stay related to maternity and newborn care may be provided if the attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or by the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for a shorter length of stay based upon evaluation of the mother and newborn. Such an earlier discharge may only be required if there are benefits and availability of a post-discharge Physician office visit or an in- home nurse visit to verify the condition of the infant in the first 48 hours after discharge.

Please note, as with all other services, benefits will only be provided for maternity services and/or care of the newborn child when such services have been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider. If you choose to have your obstetrical or pediatric care rendered by a Physician whose services have not been authorized by your Participating IPA/Participating Medical Group or Woman's Principal Health Care Provider, the Plan will neither provide benefits for such care nor coordinate benefits with any other health care coverage that you may have.

Other Reproductive Services

Your coverage includes benefits for abortion care. Benefits for abortion care are the same as your benefits for any other condition under this HOSPITAL BENEFITS Section.

URGENT CARE

This benefit provides medically necessary Outpatient care if you are outside the Health Care Plan's service area and experience an unexpected illness or injury that would not be considered an Emergency Medical Condition, but which should be treated before returning home. Services usually are provided at a Physician's office. If you require such urgent care, you should contact the Claim Administrator at 1-800-810-BLUE. You will be given the

names and addresses of nearby participating Physicians and Hospitals that you can contact to arrange an appointment for urgent care.

Your Cost for Urgent Care Treatment

100% of the Provider's Charge will be paid for urgent care received outside of the Health Care Plan's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet. Your Primary Care Physician or Woman's Principal Health Care Provider is responsible for coordinating all of your health care needs. Therefore, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible if Inpatient Hospital care is required.

FOLLOW-UP CARE

If you will be traveling and know that you will require follow-up care for an existing condition, contact the Claim Administrator at 1-800-810-BLUE. You will be given the names and addresses of nearby participating Physicians that you can contact to arrange the necessary follow-up care. (Examples of follow-up care include removal of stitches, removal of a cast, Physical Therapy, monitoring blood tests, and kidney dialysis.)

Your Cost for Follow-Up Care Treatment

100% of the Provider's Charge will be paid for follow-up care received outside of the Health Care Plan's service area. You will be responsible for any Copayment(s) or Coinsurance, if applicable.

BENEFIT PAYMENT FOR HOSPITAL SERVICES

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you are responsible for paying 10% of the Inpatient Hospital charges, after you have met the program deductible.

10% of the Provider's Charge will be paid for outpatient surgery, after you have met the program deductible.

SUPPLEMENTAL BENEFITS

When you are being treated for an illness or injury, your treatment may require the use of certain special services or supplies in addition to those provided in the other benefit sections of this Benefit Booklet. The Health Care Plan includes benefits for certain supplemental services and supplies and this section of your Benefit Booklet explains what those benefits are.

Remember, these services and supplies must be provided or ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

COVERED SERVICES

The Health Care Plan includes benefits for the following Covered Services:

- **Blood and Blood Components**
- **Medical and Surgical Dressings, Supplies, Casts and Splints** — Benefits will be provided for medical and surgical dressings, supplies, casts and splints.
- **Oxygen and its administration** — Benefits will be provided for oxygen and its administration.
- **Naprapathy Services** — Benefits will be provided for Naprapathy Services when rendered by a Naprapath.
- **Prosthetic Devices** — Benefits will be provided for prosthetic devices, special appliances and surgical implants required for an illness or injury when:

  1. they are required to replace all or part of an organ or tissue of the human body; or
  2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

  Adjustments, repairs and replacements of these devices, appliances and implants are also covered when required because of wear or a change in your condition. Benefits will not be provided for dental appliances or for replacement of cataract lenses unless a prescription change is required.

- **Hearing Implants** — Benefits will be provided for bone anchored hearing aids and cochlear implants.

  Note that you may have additional Covered Services as provided in the HEARING AID BENEFITS section of this Benefit Booklet.

- **Orthotic Devices** — that is, a supportive device for the body or a part of the body, head, neck or extremities including, but not limited to leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition as determined by your Primary Care Physician or Woman's Principal Health Care Provider.

- **Durable Medical Equipment** — that is, durable equipment which primarily serves a medical purpose, is appropriate for home use and generally is not useful in the absence of injury or disease. Benefits will be provided for the rental of a piece of equipment (not to exceed the total cost of equipment) or purchase of the equipment. Durable Medical Equipment must be rented or purchased from a Plan contracting durable medical equipment provider. Contact your Participating IPA/Participating Medical Group prior to purchasing or renting such equipment.

Examples of Durable Medical Equipment are wheelchairs, Hospital beds, glucose monitors, lancets and lancing devices and ventilators. Benefits will not be provided for strollers, electric scooters, back-up or duplicate equipment, ramps or other environmental devices, or clothing or special shoes.

YOUR COST FOR COVERED SERVICES

100% of the Provider's Charge will be paid for the Covered Services specified above.

EMERGENCY CARE BENEFITS

This section of your Benefit Booklet explains your emergency care benefits.

Notwithstanding anything in your Benefit Booklet to the contrary, for emergency care benefits rendered by Providers who are not part of the Health Care Plan's network or otherwise contracted with the Claim Administrator, the Provider's Charge shall be the amount negotiated with Providers for emergency care benefits furnished.

This amount is calculated excluding any Copayment or Coinsurance imposed with respect to the participant.

IN-AREA TREATMENT OF AN EMERGENCY

You are considered to be in your Participating IPA's/Participating Medical Group's treatment area if you are within 30 miles of your Participating IPA/Participating Medical Group.

Although you may go directly to the nearest Hospital emergency room to obtain treatment for an Emergency Medical Condition, we recommend that you contact your Primary Care Physician or Woman's Principal Health Care Provider first if you are in your Participating IPA's/Participating Medical Group's treatment area.

Benefits will be limited to the initial treatment of your emergency in the emergency room prior to stabilization unless further treatment is ordered by your Primary Care Physician or Woman's Principal Health Care Provider. If Inpatient Hospital care is required, it is especially important for you or your family to contact your Primary Care Physician or Woman's Principal Health Care Provider as soon as possible. All Participating IPA's/Participating Medical Groups have 24 hour phone service.

Payment for In-Area Emergency Treatment

Benefits for emergency treatment received in your Participating IPA's/Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $250.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

Emergency services received for the treatment of criminal sexual assault or abuse will be paid at 100% of the Provider's Charge. Benefits will not be subject to any deductible, Coinsurance, and/or Copayment.

OUT-OF-AREA TREATMENT OF AN EMERGENCY

If you are more than 30 miles away from your Participating IPA/Participating Medical Group and need to obtain treatment for an Emergency Medical Condition, benefits will be provided for the Hospital and Physician services that you receive.

Benefits are available for the initial treatment of the emergency and for related follow-up care but only if it is not reasonable for you to obtain the follow-up care from your Primary Care Physician or Woman's Principal Health Care Provider.

Payment for Out-of-Area Emergency Treatment

Benefits for emergency treatment received outside of your Participating IPA's/ Participating Medical Group's treatment area will be paid at 100% of the Provider's Charge.

However, each time you receive emergency treatment in a Hospital emergency room, you will be responsible for a Copayment of $250.

Should you be admitted to the Hospital as an Inpatient, benefits will be paid as explained in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

Emergency services received for the treatment of criminal sexual assault or abuse will be paid at 100% of the Provider’s Charge. Benefits will not be subject to any deductible, Coinsurance, and/or Copayment.

EMERGENCY AMBULANCE BENEFITS

Benefits for emergency ambulance transportation are available when:

1. such transportation is ordered by your Primary Care Physician or Woman's Principal Health Care Provider; or
2. the need for such transportation has been reasonably determined by a Physician, public safety official or other emergency medical personnel rendered in connection with an Emergency Medical Condition.

Benefits are available for transportation between your home or the scene of an accident or medical emergency and a Hospital or Skilled Nursing Facility. If there are no facilities in the local area equipped to provide the care needed, benefits will be provided for transportation to the closest facility that can provide the necessary services. Benefits will not be provided for long distance trips or for the use of an ambulance because it is more convenient than other transportation.

10% of the Provider's Charge will be paid for emergency ambulance transportation.

SUBSTANCE USE DISORDER TREATMENT BENEFITS

The Health Care Plan includes benefits for the treatment of Substance Use Disorder.

Covered Services are the same as those provided for any other condition, as specified in the other benefit sections of this Benefit Booklet. In addition, benefits are available for Covered Services provided by a Substance Use Disorder Treatment Facility or a Residential Treatment Center in the Health Care Plan's Network. To obtain benefits for Substance Use Disorder Treatment, they must be authorized by your Primary Care Physician or Woman's Principal Health Care Provider.

INPATIENT BENEFITS

There are no limits on the number of days available to you for care in a Hospital or other eligible facility.

Each time you are admitted as an Inpatient to a Hospital, Skilled Nursing Facility or Residential Treatment Center, you are responsible for paying 10% of the Inpatient Hospital charges, after you have met the program deductible whether or not referred by your Primary Care Physician or Woman's Principal Health Care Provider.

COST TO YOU FOR OUTPATIENT BENEFITS

Benefits for Outpatient office visits for Substance Use Disorder Treatment are subject to a $20 Copayment per visit and then will be paid at 100% of the Provider's Charge.

In addition, benefits for Outpatient Substance Use Disorder Treatment visits to a Specialist Physician's office are subject to a Copayment of $20 per visit and then will be paid in full.

Detoxification

Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet, as for any other condition.

AWAY FROM HOME CARE® BENEFITS

The Claim Administrator is a participant in a nationwide network of Blue Cross and Blue Shield affiliated plans. This enables the Claim Administrator to provide you with Guest Membership benefits when you are outside the service area of the Health Care Plan.

GUEST MEMBERSHIP

If you will be living outside of the Home Plan's service area for more than 90 days, but will maintain a permanent residence within the Health Care Plan's service area, the Home Plan will establish a Guest Membership for you with a Host Plan serving the area in which you will be staying.

Under this arrangement, the Health Care Plan is referred to as the "**Home Plan**." The Blue Cross and Blue Shield plan in the area in which you are temporarily residing is called the "**Host Plan**."

This would apply for members who are:

1. On an extended work assignment in another state for a period of 90 days to six months;
2. Long term travelers who will be out of the Home Plan's service area for 90 days to six months;
3. Eligible children at school out-of-state for periods of 90 days to one year; or
4. Eligible dependents living away from the employee's household in another state for periods of 90 days to one year.

Guest memberships for eligible children who are at school out-of-state or for eligible dependents who live in another state may be renewed at the end of the period.

You will select a Primary Care Physician in your Guest Membership's area, just as you have within your home area. This Primary Care Physician will be responsible for coordinating all of your health care needs.

You may contact your Employer or Employee Benefits Department to initiate the establishment of a Guest Membership, or you may call Member Services directly at 18008922803.

Benefits for Guest Membership

Each Host Plan establishes its own Guest Membership benefits. Consequently, your Guest Membership Copayment may differ from your Home Plan Copayments. However, all Basic Services will be covered. The Host Plan will provide you with an explanation of your benefits and Copayments.

HUMAN ORGAN TRANSPLANT BENEFITS

The Health Care Plan includes benefits for human organ and tissue transplants when ordered by your Primary Care Physician or Woman's Principal Health Care Provider and when performed at a center for human organ transplants that has been approved under the Health Care Plan by the Claim Administrator. To be eligible for benefits, your Primary Care Physician or Woman's Principal Health Care Provider must contact the office of the Claim Administrator's Medical Director prior to scheduling the transplant Surgery.

All of the benefits specified in the other benefit sections of this Benefit Booklet are available for Surgery performed to transplant an organ or tissue. In addition, benefits will be provided for transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada. Benefits will also be available for immunosuppressive drugs, donor screening and identification costs, under approved matched unrelated donor programs. Payment for Covered Services received will be the same as that specified in those benefit sections.

Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:

— If both the donor and recipient have benefits with the Health Care Plan, each will have his/her benefits paid by his or her own program.

— If you are the recipient and your donor does not have coverage from any other source, the benefits of the Health Care Plan will be provided for both you and your donor. The benefits provided for your donor will be charged against your benefits under this Benefit Booklet.

— If you are the donor and coverage is not available to you from any other source, the benefits of the Health Care Plan will be provided for you. However, benefits will not be provided for the recipient.

Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Primary Care Physician or Woman's Principal Health Care Provider, and you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Benefit Booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

— Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

In addition to the other exclusions of this Benefit Booklet, benefits will not be provided for the following:

1. Organ transplants, and/or services or supplies rendered in connection with an organ transplant, which are Investigational as determined by the appropriate technological body.
2. Drugs which are Investigational.
3. Storage fees.
4. Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
5. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
6. Travel time or related expenses incurred by a Provider.
7. Meals.

HOSPICE CARE BENEFITS

The Health Care Plan includes benefits for services received in a Hospice Care Program. For benefits to be available for these services, they must have been ordered by your Primary Care Physician or Woman's Principal Health Care Provider.

In addition, they must be rendered by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less as certified by your Primary Care Physician or Woman's Principal Health Care Provider; and you will no longer benefit from standard Medical Care, or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care Program;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Services.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Benefit Booklet.

Benefits are subject to the same payment provisions and day limitations specified in the HOSPITAL BENEFITS and PHYSICIAN BENEFITS sections of this Benefit Booklet, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Coordinated Home Care Program or Physician).

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This section of your Benefit Booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are medically necessary.

Although you can go to the Pharmacy of your choice, benefits will only be provided for drugs and supplies when purchased through a Participating Pharmacy. However, benefits for drugs and supplies purchased outside of a Participating Pharmacy network will only be provided in the case of an emergency condition. You can visit the Plan's website at www.bcbsil.com for a list of Participating Pharmacies or call the customer service toll-free number on your identification card. The Pharmacies that are Participating or Specialty Providers may change. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

The benefits of this section are subject to all of the terms and conditions of this Benefit Booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS — WHAT IS NOT COVERED sections of this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

NOTE: The use of an adjective such as Participating or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Pharmacy.

For purposes of this benefit section only, the following definitions shall apply:

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Preferred or Non-preferred Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Preferred or Non-Preferred Brand Name.

NON-PREFERRED BRAND NAME DRUG....means a Brand Name Drug that is identified on the applicable Drug List as a Non-Preferred Brand Name Drug. The Drug List is found at the website stated in the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS section.

PREFERRED BRAND NAME DRUG....means a Brand Name Drug that is identified on the Drug List. Drugs that are not on the Drug List may be subject to the Non-Preferred Brand Name Copayment Amount Coinsurance Amount. The Drug List is found at the website stated in the OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS section.

COINSURANCE AMOUNT.....means Copayment that is a percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or non-Participating Pharmacy.

COMPOUND DRUGS.....mean those drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the correct dosage, size, or form.

COPAYMENT AMOUNT.....means the dollar amount or Coinsurance Amount paid by you for each Prescription filled or refilled through a Participating Pharmacy or non-Participating Pharmacy.

COVERED DRUGS.....means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

(i) Which is medically necessary and is ordered by a Health Care Practitioner naming you as the recipient;

(ii) For which a written or verbal Prescription is provided by a Health Care Practitioner;

(iii) For which a separate charge is customarily made;

(iv) Which is not consumed or administered at the time and place that the Prescription is written;

(v) For which the FDA has given approval for at least one indication; and

(vi) Which is dispensed by a Pharmacy and is received by you while covered under this benefit section, except when received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this benefit section).

DRUG LIST.....means a list of drugs that may be covered under this OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFITS and related services section of this Benefit Booklet. A current list is available on our website at https://www.bcbsil.com other website. You may also contact a Customer Service Representative at the telephone number sown on the back of your Identification Card for more information.

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with the Plan or the entity chosen by the Plan to

administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Plan or the entity chosen by the Plan to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

(i) the charge which the particular Pharmacy usually charges for Covered Services, or

(ii) the agreed upon cost between the Participating Pharmacy and the Plan or the entity chosen by the Plan to administer its prescription drug program, whichever is lower.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, the Plan utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy or your Physician will adjudicate as generic. Generic Drugs are listed on the Drug List which is available on the Plan's website at www.bcbsil.com.You may also contact customer service at the toll-free number indicated on the back of your identification card.

HEALTH CARE PRACTITIONER.....means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

LEGEND DRUGS.....means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

MAINTENANCE DRUGS.....means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

NON-PARTICIPATING PHARMACY oR NON-PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, mail order Pharmacy or specialty drug Pharmacy which has not entered into a written agreement with the Plan to provide pharmaceutical services to you or an entity which has not been chosen by the Plan to administer its prescription drug program services to you at the time you receive the services.

PARTICIPATING PHARMACY OR PARTICIPATING PRESCRIPTION DRUG PROVIDER.....means an independent retail Pharmacy, chain of retail Pharmacies, mail order Pharmacy or specialty drug Pharmacy which has entered into a written agreement with the Plan to provide pharmaceutical services to you or an entity chosen by the Plan to administer its prescription drug program services to you at the time you receive the services.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTION.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Prescriptions written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this benefit section.

SPECIALTY DRUGS.....Specialty medications are: used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. In addition, patient support and/or education may be required for these drugs. These drugs often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

SPECIALTY PHARMACY PROVIDER.....means a Participating Prescription Drug Provider that has a written agreement with the Plan or the entity chosen by the Plan to administer its prescription drug program to provide Specialty Drugs to you.

ABOUT YOUR BENEFITS

Drug List

Drugs listed on the *Drug List* are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the *Drug List*. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved, for inclusion on the *Drug List*. Entire drug classes are also regularly reviewed. Positive changes (e.g., adding drugs to the *Drug List*, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the *Drug List* that could have an adverse financial impact to you (e.g., drug exclusion, drugs moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur quarterly. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the *Drug List* may occur more frequently.

Call the number on the back of your Identification Card if you have any questions.

The *Drug List* and any modifications will be made available to you. By accessing the Plan's website at www.bcbsil.com website address or calling the customer service toll-free number on your identification card, you will be able to determine the *Drug List* that applies to you and whether a particular drug is on the *Drug List*.

To the extent required by law, and subject to change as described above, all Covered Drugs indicated for the treatment of Substance Use Disorders are subject to the lowest Coinsurance Amount/Copayment Amount for a Generic Drug, Brand Name Drugs or Specialty Drugs, as applicable. If your exception is denied, you may appeal the decision according to the appeals and external exception review process you receive with the denial determination.

PRIOR AUTHORIZATION/STEP THERAPY REQUIREMENT

Prior Authorization (PA): Your benefit plan requires prior authorization for certain drugs. This means that your doctor will need to submit a prior authorization request for coverage of these medications and the request will need to be approved before the medication will be covered under the Plan. You and your Physician will be notified of the prescription drug administrator's determination. If medical necessity criteria is not met, coverage will be denied and you will be responsible for the full charge incurred.

Step Therapy (ST): The Step Therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective alternatives. The program requires that members starting a new drug treatment use a prerequisite drug first when appropriate. If the prerequisite drug is not effective, a targeted drug may then be acquired in the second step. You will be required to pay the applicable Copayment for the targeted drug. Although you may be currently on therapy, your request for a targeted drug may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a prerequisite drug may be required for continued coverage of the targeted drug.

To find out more about prior authorization/step therapy requirements or to determine which drugs or drug classes require prior authorization or step therapy, you should refer to the *Drug List* by accessing the Plan's website at *www.bcbsil.com* website address or call the customer service toll-free number on your identification card. Please refer to the *Drug List* provision of this section for more information about changes to these programs.

Your prescribing health care Provider, or your authorized representative, can ask for an exception if your drug is not on (or is being removed from) the *Drug List* if the drug requires prior authorization before it may be covered, or if the drug required as part of step therapy has been found to be (or likely to be) not right for you or does not work as well in treating your condition. To request this exception, your prescribing Provider, or your authorized representative, can call the number on the back of your identification card to ask for a review. The Plan will let you, your prescribing Provider (or authorized representative) know the coverage decision within 15 days after they receive your request. If the coverage request is denied, the Plan will let you and your prescribing Provider (or authorized representative) know why it

was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, your prescribing Provider, or your authorized representative, may be able to ask for an expedited review process. The Plan will let you, your prescribing Provider (or authorized representative) know the coverage decision within 3 days after they receive your request for an expedited review. If the coverage request is denied, the Plan will let you and your prescribing Provider (or authorized representative) know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

Dispensing Limits

Drug dispensing limits are designed to help encourage medication use as intended by the FDA. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per prescription, quantity of covered medication in a given time period, coverage only for members within a certain age range. The Plan evaluates and updates dispensing limits as frequently as quarterly or annually.

If you require a prescription in excess of the dispensing limit established by the Plan, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. If medically necessary criteria is not met, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Payment for benefits covered under this section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

To determine if a specific drug is subject to this limitation, you can refer to the Plan's website at www.bcbsil.com website address or call the customer service toll-free number on your identification card.

Day Supply

In order to be eligible for coverage under this Benefit Booklet, the prescribed day supply must be medically necessary and must not exceed the maximum day supply limitation described in this Benefit Booklet. The Plan has the right to determine the day supply. Payment for benefits covered under this benefit section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Specialty Drugs are limited to a 30 day supply. However, some Specialty Drugs have FDA Approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. For information on these drugs call the customer service toll-free number located on your

identification card. However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. For additional information about early refills, please see the Prescription Refills provision below.

Abortifacients

Benefits will be provided at no charge for FDA-approved abortifacients and follow-up services, when obtained from a Participating Provider.

Hormonal Therapy for Gender Dysphoria

Benefits will be provided at no charge for FDA-approved hormonal therapy medications for the treatment of gender dysphoria, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider.

HIV Post-Exposure Prophylaxis

Benefits will be provided at no charge for FDA-approved HIV post-exposure prophylaxis drugs, when obtained from a Participating Pharmacy, and for follow-up services, when obtained from a Participating Provider.

Controlled Substances Limitation

If it is determined that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review for medically necessary, appropriateness. Restrictions may include, but not limited to, coverage to services provided by a certain Provider and or/Pharmacy for the prescribing and dispensing of the controlled substance medication and or limiting coverage to certain quantities. Additional Coinsurance Amounts and/or Copayment Amounts and any deductible may apply.

Prescription Refills

You are entitled to synchronize your Prescription refills for one or more chronic conditions. Synchronization means the coordination of medication refills for two or more medications that you may be taking for one or more chronic conditions such that medications are refilled on the same schedule for a given period of time, if the following conditions are met:

- The prescription drugs are covered under this Benefit Booklet or have received an exception approval as described under the Drug List provision above;
- The prescription drugs are maintenance medications and have refill quantities available to be refilled at the time of synchronization;
- the medications are not Schedule II, III, or IV controlled substances as defined in the Illinois Controlled Substances Act;

- All utilization management criteria (as described under the Prior Authorization/Step Therapy Requirement provision above) for prescription drugs have been met;
- The prescription drugs can be safely split into short-fill periods to achieve synchronization; and
- The prescription drugs do not have special handling or sourcing needs that require a single, designated Pharmacy to fill or refill the Prescription.

When necessary to permit synchronization, the Plan will prorate the Copayment Amount or Coinsurance Amount, on a daily basis, due for Covered Drugs based on the proportion of days the reduced Prescription covers to the regular day supply as described below under the **BENEFIT PAYMENT FOR PRESCRIPTION DRUGS** provision in this benefit section.

COVERED SERVICES

Benefits for medically necessary Covered Drugs are available if the drug:

1. Is on the *Drug List*, and

2. Has been approved by the FDA for the diagnosis and condition for which it was prescribed; or

3. Has been approved by the FDA for at least one indication and is recognized by substantially accepted peer-reviewed medical literature for treatment of the indication for which the drug is prescribed to treat you for a chronic, disabling, or life threatening illness.

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, the Plan may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this benefit section, the drug purchased will not be covered under any benefit level.

Drugs which are not included on the Drug List, unless specifically covered elsewhere in this benefit booklet and/or such coverage is required in accordance with applicable law or regulations.

A separate Copayment Amount will apply to each fill of a medication having a unique strength, dosage, or dosage form.

Injectable Drugs

Benefits are available for medically necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided under this benefit section for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs

Benefits are available for immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs

Benefits are available for fertility drugs in connection with the diagnosis and/ or treatment of Fertility which are self-administered that require a written prescription by federal law.

Self-Administered Cancer Medications

Benefits will be provided for self-administered cancer medications, including pain medication

Topical Anti-Inflammatory Acute and Chronic Pain Medication

Benefits will be provided for Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

Contraceptive Drugs

Benefits are available for contraceptive drugs and products shown on the *Contraceptive Coverage List* Name of List that will not be subject to any deductible, Coinsurance and/or Copayment. You may access the Plan's website at *www.bcbsil.com* for more information.

Your share of the cost for all other contraceptive drugs and products will be as shown in the Benefit Highlights section of this benefit booklet.

Note: Benefits for naloxone hydrochloride, will be provided at no charge, when obtained from a Participating Pharmacy.

Opioid Antagonists

Benefits will be provided for at least one opioid antagonist drug, including the medication product, administration devices and any Pharmacy administration fees related to the dispensing of the opioid antagonist. This includes refills for expired or utilized opioid antagonists.

Opioid Medically Assisted Treatment

Benefits will be provided for Buprenorphine or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder.

Long-Term Antibiotic Therapy

Benefits will be provided for Long-Term Antibiotic Therapy, for a person with Tick-Borne Disease, when determined to be medically necessary and ordered by your Primary Care Physician or Woman's Principal Health Care Provider after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

Oral antibiotics will be covered under the Outpatient Prescription Drug Program. The member payment is indicated under the BENEFIT PAYMENT FOR PRESCRIPTION DRUGS provision of this Benefit Booklet.

An experimental drug will be covered as a Long-Term Antibiotic Therapy if it is approved for an indication by the United Stated Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

Diabetic Supplies and Blood Glucose Monitors for Treatment of Diabetes

Benefits are available for medically necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non; prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

Cancer Medications — Benefits will be provided for orally administered or self-injected cancer medications that are used to kill or slow the growth of cancerous cells. Your Copayment Amount will not apply to orally administered cancer medications

90-Day Supply Prescription Drug Program

The 90-Day Supply Prescription Drug Program provides delivery of Covered Drugs directly to your home address. In addition to the benefits described in this benefit section, your coverage includes benefits for Maintenance Drugs and diabetic supplies obtained through the 90-Day Supply Prescription Drug Program.

Some drugs may not be available through the 90-Day Supply Prescription Drug Program. If you have any questions about the 90-Day Supply Prescription Drug Program, need assistance in determining the amount of your payment, or need to obtain the mail order form, you may access the Web site at *www.bcbsil.com* or call the customer service toll-free number on your identification card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Program. To determine which drugs are Specialty Drugs or to locate a Specialty Pharmacy Provider, you should refer to the *Drug List* by accessing the Plan's website at *www.bcbsil.com* or call the customer service toll-free number on your identification card.

The Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and the Plan,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharp containers, alcohol swabs and other supplies with every shipment of FDA approved self-injectable medications, and
- Access to a pharmacist 24 hours a day, 7 days a week, 365 days each year.

YOUR COST FOR PRESCRIPTION DRUGS

How Your Cost is Determined

The amount that you are responsible for is based upon the drug tier as *described* below and shown in the Benefit Highlights section of this Benefit Booklet

- Tier 1 - includes mostly Generic Drugs and may contain some Brand Name Drugs.
- Tier 2 - includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 3 - includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.

If you or your Provider request a Brand Name Drug when a Generic Drug is available, you will pay the applicable Copayment Amount and/or Coinsurance based on current tier of Brand Name Drug plus the difference between the allowable amount of the Brand Name Drug and the allowable amount of the Generic Drug, except as otherwise provided in this Benefit Booklet.

To verify your payment amount for a drug, visit the Plan's website at www.bcbsil.com website address and log into Blue Access for Members or call the number on the back of your identification card. Benefits will be provided as shown in the Benefit Highlights section of this Benefit Booklet.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will be applied to your program deductible or out-of-pocket expense limit.

Out-of-Pocket Expense Limit

If during one calendar year your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) for Outpatient prescription drugs and diabetic supplies equals $2,500, any additional eligible Claims for Outpatient prescription drugs and diabetic supplies during that calendar year will be paid in full at no cost to you.

If you have Family Coverage and your out- of- pocket expense (the amount remaining unpaid after benefits have been provided) for Outpatient prescription drugs and diabetic supplies equals $5,000 during one calendar year then for the rest of that calendar year all other family members will have benefits paid in full at no cost to them.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will be applied to your program deductible or out-of-pocket expense limit.

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

34-Day Supply Prescription Drug Program

Benefit payment for the 34-day supply prescription drug program

The benefits you receive and the amount you pay for drugs will differ depending upon the type of drugs, or diabetic supplies or insulin and insulin syringes you purchase, whether or not the drug is self-injectable and whether or not the drug is purchased from a Participating Pharmacy.

When you purchase drugs from a Participating Prescription Drug Provider, you will not be charged any amount other than the specified Copayment amount. The Copayment amounts are shown in the BENEFIT HIGHLIGHTS section of this Benefit Booklet. You will be charged the Copayment amount for each prescription. There is no charge to you for diabetic supplies.

When you purchase Specialty Drugs from a Participating Prescription Drug Provider, you will not be charged any amount other than the Coinsurance amount specified in the BENEFIT HIGHLIGHTS section of this Benefit Booklet. You will be charged the Coinsurance amount for each prescription.

One prescription means up to a 34 consecutive day supply for most medications. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the 90-day supply prescription drug program. For additional information on these drugs, contact the customer service toll-free number on your identification card.

No benefits will be provided when you purchase drugs, diabetic supplies or Specialty Drugs from a Non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider). However, if the Non-Participating Prescription Drug Provider is located outside of a Participating Pharmacy network, then benefits for drugs purchased for emergency conditions will be provided at 100% of the amount that would have been paid had you purchased such drugs from a Participating Prescription Drug Provider, minus the Copayment amount.

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

90-Day Supply Prescription Drug Program

Benefit payment for the 90-day supply prescription drug program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and diabetic supplies purchased from a Prescription Drug Provider (which may include retail or mail order pharmacies) participating in the 90-day supply prescription drug program. You will not be charged any amount other than the Copayment amount, specified in the section of this Benefit Booklet. There is no charge to you for diabetic supplies.

Benefits will not be provided for 90-day supply drugs or diabetic supplies purchased from a Prescription Drug Provider not participating in the 90-day supply program.

Should you choose to obtain a 90-day supply Prescription Drug Order from a mail order Pharmacy, you can obtain an order form by calling the customer service toll-free number on your identification card.

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

EXCLUSIONS

For purposes of this benefit section only, the following exclusions shall apply:

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere mentioned in this benefit booklet and/or such coverage is required in accordance with applicable law or regulatory guideline.
2. Non-FDA approved Drugs.
3. Drugs which do not by law require a Prescription from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription is obtained.
4. Devices Technologies, and/or durable medical equipment of any type (even though such devices may require a Prescription) such as, but not limited to, male condoms, therapeutic devices, artificial appliances, digital

health technologies and/or applications or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).

5. Pharmaceutical aids, such as, excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including but not limited to, preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.)
6. Administration or injection of any drugs.
7. Vitamins (except those vitamins which by law require a Prescription and for which there is no non-prescription alternative).
8. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
10. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
11. Repackaged medications and institutional Packs and drugs which are repackaged by anyone other than the original manufacturer.
12. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this benefit section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law.
13. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Benefit Booklet. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
14. Drugs required by law to be labeled: “Caution – Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs, or are Experimental/Investigational, except as specifically mentioned in this Benefit Booklet.
15. Drugs, that the use or intended use of which would be illegal, abusive, not medically necessary, or otherwise improper.

16. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
17. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.
18. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
19. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
20. Prescriptions for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined.
21. Athletic performance enhancement drugs.
22. Allergy serum and allergy testing materials.
23. Injectable drugs, except Specialty Drugs or those determined by the Plan to be self-administered.
24. Some drugs have therapeutic/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under this benefits section, the drug purchased will not be covered under any benefit level.
25. Compound Drugs.
26. Medications in depot or long acting formulations that are intended for use longer than the covered days supply amount.
27. Drugs determined by the Plan to have inferior efficacy or significant safety issues.
28. Devices and pharmaceutical aids.
29. Surgical supplies.
30. Ostomy products.
31. Diagnostic agents, (except for diabetic testing supplies or test strips).
32. General anesthetics.
33. Bulk powders.
34. Male condoms.
35. Any New-to-Market FDA-approved medications which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

36. Drugs that are not considered medically necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
37. Certain drug classes where there are over-the-counter alternatives available.
38. Drugs without superior clinical efficacy which have lower cost therapeutics.

HEARING AID BENEFITS

Your benefits include coverage for hearing aids when ordered by your Primary Care Physician or Woman's Principal Health Care Provider. Your Hearing Aid benefit period begins on the date the you first receive a Hearing Aid after the date that your coverage began and continues through the benefit period. Later benefit periods will begin on the first day that you receive hearing aid after expiration of your prior established Hearing Aid benefit period.

Hearing Aids for Individuals Under the Age of 18

Benefits will be provided for Hearing Aids for individuals under the age of 18 when a Hearing Care Professional (upon referral from your Primary Care Physician or Woman's Principal Health Care Provider) prescribes a Hearing Aid to augment communication as follows:

— one Hearing Aid will be covered for each ear every 24 months;

— related services, such as audiological examinations and selection, fitting, and adjustment or ear molds to maintain optimal fit will be covered when deemed medically necessary by a Hearing Care Professional; and

— Hearing Aid repairs will be covered when deemed medically necessary.

Hearing Aids for Individuals Age of 18 or Over

Your benefits include coverage for Hearing Aids for individuals over the age of 18 when a Hearing Care Professional (upon the referral from your Primary Care Physician or Woman's Principal Health Care Provider) prescribes a Hearing Aid to augment communication.

Benefits are as follows:

— one Hearing Aid will be covered for each ear 24 months; and

— related services, such as audiological examinations and selection, fitting, and adjustment or ear molds to maintain optimal fit will be covered when deemed medically necessary by a Hearing Care Professional; and

— Hearing Aid repairs will be covered when deemed medically necessary.

Benefits will be provided for one Hearing Aid per ear each benefit period.

Benefits will not be provided for repair of a Hearing Aid or for replacement of a Hearing Aid unless the replacement would otherwise be eligible according to the benefit period limitations specified above.

Benefits for Hearing Aids will be provided for up to a maximum of $2,500 per benefit period for individuals age 18 and over.

Benefits will also be provided for Hearing Aids batteries and codes.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

Pre-Admission Certification and Concurrent Review are two programs that have been established to ensure that you receive the most appropriate and cost effective health care.

PRE-ADMISSION CERTIFICATION

Pre-Admission Certification applies when you need to be admitted to a Hospital as an Inpatient in other than an emergency situation. Prior to your admission, your Primary Care Physician or Woman's Principal Health Care Provider must obtain approval of your admission from the Participating IPA/Participating Medical Group with which he/she is affiliated or employed. The Participating IPA/Participating Medical Group may recommend other courses of treatment that could help you avoid an Inpatient stay. It is your responsibility to cooperate with any recommendations made by the Participating IPA/Participating Medical Group.

CONCURRENT REVIEW

Once you have been admitted to a Hospital as an Inpatient, your length of stay will be reviewed by the Participating IPA/Participating Medical Group. The purpose of that review is to ensure that your length of stay is appropriate given your diagnosis and the treatment that you are receiving. This is known as Concurrent Review.

If your Hospital stay is longer than the usual length of stay for your type of condition, the Participating IPA/Participating Medical Group will contact your Primary Care Physician or Woman's Principal Health Care Provider to determine whether there is a medically necessary reason for you to remain in the Hospital. Should it be determined that your continued stay in the Hospital is not medically necessary, you will be informed of that decision, in writing, and of the date that your benefits for that stay will end.

EXCLUSIONS – WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— Services or supplies that are not specifically stated in this Benefit Booklet.

— Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in the EMERGENCY CARE BENEFITS section, SUBSTANCE USE DISORDER TREATMENT BENEFITS section, HOSPITAL BENEFITS section and, routine vision examinations, in the PHYSICIAN BENEFITS section of this Benefit Booklet.

— Services or supplies that were received prior to the date your benefits began, or after the date that your benefits were terminated subject to the Extension of Benefits in Case of Discontinuance of Benefits provision in Eligibility.

— Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government whether or not those payments or benefits are received (except in the case of Medicare), except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Health Care Plan has provided benefits for the services or supplies rendered in connection with such injury.

— Custodial Care Service.

— Long Term Care Services.

— Respite Care Services, except as specifically mentioned under Hospice Care Benefits.

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other anti-social actions which are not specifically the result of Mental Illness. However, this exclusion does not include services or supplies

provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Special education therapy such as music therapy or recreational therapy, except as specifically provided for in this Benefit Booklet.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.

— Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in this Benefit Booklet.

— Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.

— Nutritional items such as infant formula, weight-loss supplements, over-the- counter food substitutes, non-prescription vitamins and herbal supplements, except as stated in this Benefit Booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Hypnotism.

— Inpatient Private Duty Nursing Service.

— Routine foot care, except for persons diagnosed with diabetes.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Benefit Booklet.

— Maintenance Care.

— Self-management training, education and medical nutrition therapy, except as specifically stated in this Benefit Booklet.

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services.

— Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Benefit Booklet.

— Repair or replacement of appliances and/or devices due to misuse or loss, except as specifically mentioned in this Benefit Booklet.

— Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

— Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this Benefit Booklet.

— Wigs (also referred to as cranial prostheses).

— Abortion, regardless of the reason for the abortion.

— Sterilization or the reversal of sterilization.

— Eyeglasses, contact lenses or hearing aids, except as specifically provided for in this Benefit Booklet.

— Dental care, except as directly required for the treatment of a medical condition or as otherwise provided for in this Benefit Booklet.

— Any services and/or supplies provided to you outside the United States, unless they are received for an Emergency Medical Condition, notwithstanding any provision in the Benefit Booklet to the contrary.

— Benefits will not be provided for any self-administered drugs dispensed by a Physician.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this Benefit Program when you or your covered dependent has health care coverage under more than one Benefit Program. COB does not apply to the Outpatient Prescription Drug Program Benefits.

The order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Benefit Program are determined before or after those of another Benefit Program. The benefits of this Benefit Program:

1. Shall not be reduced when, under the order of benefit determination rules, this Benefit Program determines its benefits before another Benefit Program; but
2. May be reduced when, under the order of benefits determination rules, another Benefit Program determines its benefits first. This reduction is described below in "When this Benefit Program is a Secondary Program."

In addition to the Definitions section of this Benefit Booklet, the following definitions apply to this section:

ALLOWABLE EXPENSE....means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under this definition unless your stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Benefit Program, or if a private Hospital room is the only room available.

When a Benefit Program provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

BENEFIT PROGRAM.....means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

(i) Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(ii) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the Social Security Act).

Each contract or other arrangement under (i) or (ii) above is a separate benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Benefit Program.

CLAIM DETERMINATION PERIOD.....means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Benefit Program, or any part of a year before the date this COB provision or a similar provision takes effect.

PRIMARY PROGRAM or SECONDARY PROGRAM.....means the order of payment responsibility as determined by the order of benefit determination rules.

When this Benefit Program is the Primary Program, its benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its benefits are determined after those of the other Benefit Program and may be reduced because of the other program's benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs, and may be a Secondary Program as to a different program or programs.

ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program that has its benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of benefit payments using the first of the following rules that applies:

1. Non-Dependent or Dependent

   The benefits of the Benefit Program that covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the Benefit Program that covers the person as dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

   a. Secondary to the Benefit Program covering the person as a dependent; and

   b. Primary to the Benefit Program covering the person as other than a dependent, for example a retired employee.

2. Dependent Child if Parents not Separated or Divorced

   Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a dependent of different persons, (i.e., "parents").

   a. The benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but

   b. If both parents have the same birthday, the benefits of the Benefit Program that covered the parents longer are determined before those of the Benefit Program that covered the other parent for a shorter period of time.

   However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of benefits, the rule in the other Benefit Program will determine the order of benefits.

3. Dependent Child if Parents Separated or Divorced

   If two or more Benefit Programs cover a person as a dependent child of divorced or separate parents, benefits for the child are determined in this order:

   a. First, the program of the parent with custody of the child;

   b. Then, the program of the spouse of the parent with the custody of the child; and

   c. Finally, the program of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This does not apply with respect to any Claim Determination Period or Benefit Program year during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify the Claim Administrator and, upon its request, to provide a copy of the court decree.

4. Dependent Child if Parents Share Joint Custody

   If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of benefit determination rules outlined in 2 above.

5. Young Adults as a Dependent

   For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, rule 8, "Length of Coverage" applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule of rule 2 to the dependent child's parent or parents and the dependent's spouse.

6. Active or Inactive Employee

   The benefits of a Benefit Program that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Benefit Program that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of benefits, this rule shall not apply.

7. Continuation Coverage

   If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of benefit determination:

   a. First, the benefits of a Benefit Program covering the person as an employee, member or subscriber (or as that person's dependent);

   b. Second, the benefits under the continuation coverage.

   If the other Benefit Program does not contain the order of benefits determination described within this section, and if, as a result, the programs do not agree on the order of benefits, this requirement shall be ignored.

8. Length of Coverage

   If none of the above rules determines the order of benefits, the benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the benefits of this Benefit Program may be reduced.

The benefits of this Benefit Program will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Benefit Program will be reduced so that they and the benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the benefits of this Benefit Program are reduced as described, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Program.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Health Care Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Health Care Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Benefit Program must give the Health Care Plan any facts it needs to pay the Claim. The Health Care Plan may share such information with the Claim Administrator.

FACILITY OF PAYMENT

A payment made under another Benefit Program may include an amount that should have been paid under this Benefit Program. If it does, the Health Care Plan may pay that amount to the organization that made the payment under the other Benefit Program. That amount will then be treated as though it were a benefit paid under the Health Care Plan. The Health Care Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by the Health Care Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The foregoing notwithstanding, you will only be responsible for any applicable Copayments, deductibles and/or Coinsurance as described in this Benefit Booklet.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

ADDITIONAL BENEFITS — SAVINGS

The amount by which your benefits under the Benefit Program of the Health Care Plan have been reduced is called your "savings." Savings can be used to pay for services that are not covered under the Health Care Plan provided that the services are covered under another Benefit Program and

were not completely paid for under that Benefit Program. Savings can only be used to pay for services rendered in the same calendar year in which the Claim that earned the savings is actually processed.

Please notify the Plan, by calling customer service, if there are expenses incurred during this calendar year which may entitle you to these additional benefits.

HOW TO FILE A CLAIM AND APPEALS PROCEDURES

When you receive care from your Primary Care Physician or from another Provider who is affiliated with your Participating IPA/Participating Medical Group, or from your Woman's Principal Health Care Provide, a Claim for benefits does not have to be filed with the Claim Administrator. All you have to do is show your ID card to your Provider. However, to receive benefits for care from another Physician or Provider, you must be referred to that Provider by your Primary Care Physician or Woman's Principal Health Care Provider.

When you receive care from Providers outside of your Participating IPA/Participating Medical Group (i.e. emergency care, medical supplies), usually all you have to do to receive your benefits under this Benefit Booklet is to, again, show your ID card to the Provider. Any Claim filings required will be done by the Provider.

There may be situations when you have to file a Claim yourself (for example, if a Provider will not file one for you). To do so, send the following to the Claim Administrator:

1. an itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service and the Claim Charge);
2. the Eligible Person's name and ID card number,
3. the patient's name, age and sex;
4. any additional relevant information. Mail all of that information to:

Blue Cross and Blue Shield
300 East Randolph Street
Chicago, Illinois 60601-5099

In any case, it is your responsibility to make sure that the necessary Claim information has been provided to the Claim Administrator. Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

If you have any questions about a Claim, call the Claim Administrator Member Services at 1-800-892-2803.

INTERNAL CLAIM DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIM DETERMINATIONS

When the Claim Administrator receives a properly submitted claim, the Claim Administrator will determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for

benefits and will process claims consistent with administrative practices and procedures established by your Plan. You, your valid assignee, your authorized representative, or Provider will be notified of the Claim Administrator's benefit decision.

(For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this Benefit Booklet.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim as defined below). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review;

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator's offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your identification card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **customer service** at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees, or a Provider.

The following contact information for the Illinois Department of Insurance ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for Medical Care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

b. Pre-Service Claim is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining Medical Care.

c. Post-Service Claim is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**24 hours****
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**48 hours after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**48 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your identification card as soon as possible to submit an Urgent Care Clinical Claim.

**Notification may be oral unless the claimant requests written notification.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	**5 days***
If your Claim is incomplete, the Claim Administrator must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**

The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days****
after receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*Notification may be oral unless the claimant requests written notification.

**This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**30 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of any adverse Claim determination:	
if the initial Claim is complete, within:	**30 days***
after receiving the completed Claim (if the initial Claim is incomplete), within:	**45 days**

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An **"Adverse Benefit Determination"** means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide in response to a Claim, Pre-Service Claim or Urgent Care Clinical

Claim or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an Ongoing Course of Treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An **expedited Clinical Appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an Ongoing Course of Treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the Ongoing Course of Treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent Clinical Appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim

Administrator at the number on the back of your identification card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

Your Right to Appeal
You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case. Send a written appeal request to: The Claim Administrator Claim Review Section P.O. Box 2401 Chicago, Illinois 60690
To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at bcbsil.com

During the course of your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. The Claim Administrator may extend

the time period described in this Benefit Booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 15 business days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you've already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a Clinical Appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care Provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

4. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;
5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;
6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
8. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
11. A description of the standard that was used in denying the claim and a discussion of the decision;
12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on his/her own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;
14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external

review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Forum Selection. In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An "**Adverse Benefit Determination**" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an Ongoing Course of Treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a

Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:

    a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

    c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and

    d. You or your authorized representative have provided all the information and forms required to process an external review.

    You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.

    The IRO must provide the following:

    a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating Provider;

(4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) 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 Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your 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 the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

OTHER THINGS YOU SHOULD KNOW

CLAIMS LIABILITY

The Claim Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

REIMBURSEMENT PROVISION

If you recover expenses for sickness or injury that occurred due to the negligence of a third party, the Health Care Plan has the right to first reimbursement for all benefits the Health Care Plan paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury.

You are required to furnish any information or assistance, or provide any documents that the Health Care Plan may reasonably require in order to exercise the Health Care Plan's rights under this provision. This provision applies whether or not the third party admits liability.

The Health Care Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Health Care Plan provided for that sickness or injury.

CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator has contracts with certain Providers and other suppliers of goods and services for the provision of and/or payment for health care goods and services to all persons entitled to health care benefits under individual and group policies or contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan described in this Benefit Booklet.

Under certain circumstances described in its contracts with such Providers and suppliers, the Claim Administrator may:

- receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which the Health Care Plan was obligated to pay the Provider or supplier, or
- pay Providers or suppliers substantially less than their Claim Charges for goods or services, by discount or otherwise, or
- receive from Providers or suppliers other substantial allowances under the Health Care Plan's contracts with them.

We understand that the Claim Administrator may receive such payments, discounts, and/ or other allowances during the term of their contract to administer the Health Care Plan.

Neither you nor us are entitled to receive any portion of any such payments, discounts, and/or other allowances. Any Copayments and/or deductibles payable by you are pre-determined fixed amounts, based upon the provisions

stated in this Benefit Booklet, and these amounts are not impacted by any discounts or contractual allowances which the Claim Administrator may receive from a Provider.

INTER-PLAN ARRANGEMENTS

Out-of-Area Services

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees"). Generally, these relationships are called “Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association (“Association"). Whenever you obtain health care services outside of the Health Care Plan’s service area and your Participating IPA's/Participating Medical Group's service area (collectively referred to in this section as “the service area"), the Claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside the service area, you will receive it from one of two kinds of health care Providers. Most Providers (“participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue"). Some Providers (“non-participating Providers") do not contract with the Host Blue. The Health Care Plan's payment practices in both instances are described below.

The Health Care Plan covers only limited health care services received outside of the service area. As used in this section, “Out-of-Area Covered Healthcare Services" include emergency care, urgent care and follow-up care obtained outside the geographic area of the service area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by your Primary Care Physician (“PCP") or Women's Principal Health Care Provider (“WPHCP").

For Inpatient facility services received in a Hospital, the Host Blue’s Participating Provider is required to obtain Prior Authorization. If Prior Authorization review is not obtained, the participating Provider will be sanctioned based on the Host Blue’s contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

BlueCard® Program

Under the BlueCard Program, when you receive Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, the Claim Administrator will remain responsible for what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a Claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no Claim forms for you to fill out. You will be

responsible for the Co- payment and/or Coinsurance amount, as stated in this Benefit Booklet.

Emergency Care Services:

If you experience a medical emergency while traveling outside the service area, go to the nearest emergency facility, urgent care facility, or other health care Provider.

Whenever you receive Out-of-Area Covered Healthcare Services outside the service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

— The billed charges for your Covered Services, or

— The negotiated price that the Host Blue makes available to the Claim Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator uses for your Claim because they will not be applied after a Claim has already been paid.

Non-Participating Healthcare Providers Outside The Service Area

Liability Calculation

Except for emergency care and urgent care, services received from a non-participating Provider outside of the service area will not be covered.

For emergency care and urgent care services received from non-participating Providers outside of your Participating IPA's/Participating Medical Group's service area, but within the Health Care Plan's service area, please refer to the EMERGENCY CARE BENEFITS section of this Benefit Booklet.

For emergency care and urgent care services that are provided outside of the service area by a non-participating Provider, the amount(s) you pay for such services will be calculated using the methodology described in the EMERGENCY CARE BENEFITS section for non-participating Providers located inside the service area. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

Outpatient Services

Physicians, urgent care centers and other Outpatient Providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide® Claim

When you pay for Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form and the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Claim Administrator, the BlueCard Worldwide service center or online at *www.bluecardworldwide.com*. If you need assistance with your Claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Notice of Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan described in this Benefit Booklet. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you. Neither you, nor us are entitled to receive any portion of any such payments, discounts and/or other allowances.

Notice of Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC. This notice is to inform you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers and the Plan have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither you, nor us are entitled to receive any portion of such rebates, in excess of any amount that may be reflected in the premium.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

All benefit payments may be made by the Claim Administrator directly to any Provider furnishing the Covered Services for which such payment is due, and the Health Care Plan and the Claim Administrator are authorized by you to make such payments directly to such Providers. However, the Health Care Plan and Claim Administrator reserve the right to pay any benefits that are payable under the terms of this Benefit Booklet directly to you, unless reasonable evidence of a properly executed and enforceable Assignment of Benefit Payment has been received by the Claim Administrator sufficiently in advance of the Claim Administrator's benefit payment. The Health Care Plan and Claim Administrator reserve the right to require submission of a copy of the Assignment of Benefit Payment.

You will not receive any notices regarding Covered Services received from your Primary Care Physician (or other Providers who are part of your Participating IPA/Participating Medical Group) because Claims do not have to be filed for those services.

Once Covered Services are rendered by a Provider, you have no right to request that the Health Care Plan or Claim Administrator not pay the Claim submitted by such Provider and no such request will be given effect. In

addition, the Health Care Plan and Claim Administrator will have no liability to you or any other person because of its rejection of such request.

Except for the assignment of benefit payment described above, neither the Health Care Plan nor a covered person's Claim for payment of benefits under the Health Care Plan is assignable in whole or in part to any person or entity at any time, and benefits under the Health Care Plan are expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer benefits or aid or attempt to aid any other person in fraudulently obtaining benefits.

FEDERAL BALANCE BILLING AND OTHER PROTECTIONS

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Illinois law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Benefit Booklet, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of this section only.

1. PCP Selection

The Plan requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family Members.

Until you make this designation, Blue Cross and Blue Shield of Illinois designates one for you. For information on how to select a PCP and for a list of the participating PCPs, contact BCBSIL at www.bcbsil.com or customer service at the toll-free number on the back of your identification card.

For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician (PCP).

2. OB/GYN Care

You are not required to obtain a referral or authorization from your Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsil.com or contact customer service at the toll-free number on the back of your identification card.

3. Continuity of Care

If you are under the care of a Participating Provider as defined in this Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for

that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

a. You are undergoing a course of treatment for a serious and complex condition,
b. You are undergoing institutional or inpatient care,
c. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
d. You are pregnant or undergoing a course of treatment for your pregnancy, or
e. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date. The Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the **CLAIM APPEAL PROCEDURES** provision in the **HOW TO FILE A CLAIM** section of this Benefit Booklet.

4. Federal No Surprises Act Definitions

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS** section of this Benefit Booklet, those terms will apply only to their use in the Benefit Booklet or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

"**Air Ambulance Services**" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"**Emergency Medical Condition**" means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"**Emergency Services**" means, for purposes of this section only,

1. a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
2. further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and
3. Covered Services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless:
    a. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
    b. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
    c. You have provided informed consent.

"**Non-Participating Provider**" means, for purposes of this section only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

"**Non-Participating Emergency Facility**" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan.

"**Participating Provider**" means, for purposes of this section only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

"**Participating Facility**" means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the Plan.

"**Qualifying Payment Amount**" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"**Recognized Amount**" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

5. Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

a. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

b. Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).

c. Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

6. Federal No Surprises Act Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-

share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

COVERED SERVICES EXPENSE LIMITATION

If you have Individual Coverage and during any one calendar year, the total amount of any Copayments, deductibles and/or Coinsurance amounts for Covered Services under the Health Care Plan equals $2,000, then any additional Copayment, deductible and/or Coinsurance amount that you pay towards Covered Services will be reimbursed by the Plan.

If you have Family Coverage and during any one calendar year, the total amount of any Copayments, deductibles and/or Coinsurance amounts that your family pays towards Covered Services equals $4,000, then any additional Copayment, deductible and/or Coinsurance amount that your family pays towards Covered Services will be reimbursed by the Plan. A family member may not apply more than the individual expense limit as described above towards the family expense limit.

In the event your Physician or the Hospital requires you to pay any additional Copayments, deductible and/or Coinsurance amounts after you have met the above provision, upon receipt of properly authenticated documentation, the Plan will reimburse to you, the amount of those Copayments, deductibles and/or Coinsurance amounts.

Copayments and deductibles required under the Health Care Plan are not to exceed 50% of the usual and customary fee for any single service.

This Covered Services expense limitation does not include:

- Services, supplies or charges excluded under the Health Care Plan

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on your behalf, that amount will be applied to your [program] deductible or out-of-pocket expense limit.

YOUR PROVIDER RELATIONSHIPS

The choice of a Hospital, Participating IPA, Participating Medical Group, Primary Care Physician or any other Provider is solely your choice and neither the Health Care Plan, nor the Claim Administrator, will interfere with your relationship with any Provider.

The Health Care Plan and Claim Administrator do not themselves undertake to provide health care services, but solely to arrange for the provision of health care services and to make payments to Providers for the Covered Services received by you. The Health Care Plan and Claim Administrator are not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Health Care Plan or Claim Administrator. Any contractual relationship between a Physician and a Hospital or other Provider should not be construed to mean that the Health Care Plan or the Claim Administrator is providing professional service.

Each Provider provides Covered Services only to Enrollees and does not interact with or provide any services to us or to the Health Care Plan (other than to a Enrollees under the plan).

FAILURE OF YOUR PARTICIPATING IPA OR PARTICIPATING MEDICAL GROUP TO PERFORM UNDER ITS CONTRACT

Should your Participating IPA or Participating Medical Group fail to perform under the terms of its contract with the Claim Administrator or fail to renew such contract, the benefits of this Benefit Booklet will be provided for you for Covered Services received from other Providers limited to Covered Services received during a thirty day period beginning on the date of the Participating IPA's/Participating Medical Group's failure to perform or failure to renew its contract with the Claim Administrator. During this thirty day period, you will have the choice of transferring your enrollment to another Participating IPA or Participating Medical Group or of transferring your benefits to any other health care coverage then being offered by us to our members or employees. Your transferred enrollment or benefits will be effective thirty-one days from the date your Participating IPA or Participating Medical Group failed to perform or failed to renew its contract with the Claim Administrator.

CONTINUITY OF CARE

If you are under the care of a Primary Care Physician or a Women's Principal Health Care Provider or other Provider who leaves the Plan's network (for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by State licensing board, and your Provider agrees, you may be able to continue receiving Covered Services with that Provider for the following:

- An Ongoing Course of Treatment for a serious acute disease or condition requiring complex ongoing care that you are currently receiving, such as,

(for example, you are currently receiving Chemotherapy, Radiation Therapy, or postoperative visits for a serious acute disease or condition);

- An Ongoing Course of Treatment for a life; threatening disease or condition and the likelihood of death is probable unless the course of the disease or condition is interrupted);
- An Ongoing Course of Treatment for the second and third trimester of pregnancy through the postpartum period; or
- An Ongoing Course of Treatment for a health condition of which a treating Provider attests that discontinuing care by the Provider who is terminating from the network would worsen the condition or interfere with anticipated outcomes.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days from the date of the notices to the Eligible Person of the Provider's termination from the network plan, or if the Enrollee has entered the second or third trimester of pregnancy at the time of the Provider's disaffiliation, a period that includes the provision of post; partum care directly related to the delivery.

If you are a new enrollee and you are receiving care for a condition that requires an Ongoing Course of Treatment or if you have entered into the second or third trimester of pregnancy, and your Physician does not belong to the Plan's network, but is within the Plan's service area, you may request the option of transition of care benefits.

You must submit a written request to the Plan for transition of care benefits within 15 business days of your eligibility effective dare, or if you have entered the second or third trimester of pregnancy at the time of the provider's disaffiliation, a period that includes the provision of post; partum care directly related to the delivery. The Plan may authorize transition of care benefits for a period up to 90 days from the effective date of enrollment. Authorization of benefits is dependent on the Physician's agreement to contractual requirements and submission of detailed treatment plan. A written notice of the Plan's determination will be sent to you within 15 business days of receipt of your request.

You have the right to appeal any decision made for a request for benefits under this provision as explained in the CLAIM APPEAL PROCEDURES provision in the **HOW TO FILE A CLAIM** section of this Benefit Booklet.

NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Benefit Booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator’s records or to you, in care of

us; and, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under this Benefit Booklet until at least 60 days have elapsed since a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this Benefit Booklet. In addition, no such action may be brought once 3 years have elapsed from the date that a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this Benefit Booklet.

VALUE BASED DESIGN PROGRAMS

The Health Care Plan and Claim Administrator have the right to offer medical management programs, quality improvement programs, and health behavior wellness incentives, maintenance, or improvement programs that allows for a reward, a contribution, a penalty, a differential in the portion of the cost to you for your benefits, a differential in medical, prescription drug or equipment Copayments, Coinsurance, deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Health Care Plan or the Claim Administrator (or entity chosen by Claim Administrator to administer the program). In addition, discount programs for various health and wellness-related or insurance-related items and services may be available from time to time. Such programs may be discontinued without notice. Contact the Employee Benefits Department or the Claim Administrator for additional information regarding any value based programs offered by us or Claim Administrator.

The Claim Administrator makes available, at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Claim Administrator's designated outside vendor and acceptance or declination of these services is optional to you. If you wish to accept such identity theft protection services, you will need to individually enroll in the program online at *www.bcbsil.com* or telephonically by calling the toll-free telephone number on your identification card. Services may automatically end when you are no longer an eligible person. Services may change or be discontinued at any time with or without notice and the neither the Health Care Plan, nor the Claim Administrator, guarantees that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under the Health Care Plan.

INFORMATION AND RECORDS

You agree that it is your responsibility to ensure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim

or Claims for bene- fits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan or its agent, and agrees that any such Provider, person, or other entity may furnish to the Health Care Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Health Care Plan may furnish similar information and records (or copies of records) to Providers, its Claim Administrator and Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish to us, the Health Care Plan or the Claim Administrator information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status, in order that the Plan be able to make Claim Payments in accordance with MSP laws.

MEDICALLY NECESSARY DISPUTE RESOLUTION

A dispute resolution process must be established in which a Physician, holding the same class of license as your Primary Care Physician, but not affiliated with either your Participating IPA or Participating Medical Group, and is jointly selected by you and/or your Participating IPA or Participating Medical Group in the event of a dispute regarding the medical necessity of a service. The Health Care Plan shall be required to cover the services should the reviewing Physician determine services to be medically necessary.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by the Claim Administrator, Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation; or, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, by the Host Blues whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health benefits sponsored by us, but solely as a result of a reduction in force, plant/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Blue Cross and Blue Shield of Illinois offers to you, if you do not reside in the Blue Cross and Blue Shield of Illinois service area, Blue Cross and Blue Shield of Illinois may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this the Claim Administrator may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your benefits under the Health Care Plan to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

OVERPAYMENT

If the Plan pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("overpayment"), the Plan has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any other insurance company or plan, or (iii) any other persons, entities, or organizations,

If no refund is received, the Plan may deduct any refund due to it from:

a. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another Plan administered ASO benefit program; or

c. Any future benefit payment made to any person or entity under another Plan insured group benefit plan or individual policy; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more participating or non-participating Providers.

Further, the Plan has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another Plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Plan or policy.

RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION; Effective July, 1 2017

A certification(s) may have been provided to the Plan that your group health plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption"). Provided that the Religious Employer Exemption is satisfied for your group health plan, then benefits under your group health plan will not include benefits for some or all of such contraceptive services. Please call customer service at the number on the back of your ID card for more information). Questions regarding the Religious Employer Exemption should be directed to your Group.

DEFINITIONS

Throughout this Benefit Booklet, many words are used which have a specific meaning when applied to the Health Care Plan. The definitions of these words are listed below in alphabetical order. **These defined words will always be capitalized when used in this Benefit Booklet.**

A1C Testing ……means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

Ambulatory Surgical Facility ……means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services, when operating within the scope of such license.

Approved Clinical Trial ……means a phase I, phase II, or phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

a) A federally funded or approved trial,

b) A clinical trial conducted under an FDA investigational new drug application, or

c) A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Autism Spectrum Disorder(s) ……means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including Asperger's disorder and pervasive developmental disorders not otherwise specified.

Behavioral Health Practitioner ……means a Physician or professional Provider who is duly licensed to render services for the treatment of Mental Illness, Serious Mental Illness or Substance Use Disorder.

Biomarker Testing ……means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to, singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

Benefit Booklet ……means this booklet.

Certified Clinical Nurse Specialist ……means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical

consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license);and

(ii) is a graduate of an advanced practice nursing program.

Certified Nurse Midwife ……means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

Certified Nurse Practitioner…..means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse (and is operating within the scope of such license); and

(ii) is a graduate of an advanced practice nursing program.

Certified Registered Nurse Anesthetist (CRNA) ……means a person who (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse (and is operating within the scope of such license); (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

Chemotherapy……means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Chiropractor……means a duly licensed chiropractor.

Civil Union……means a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

Claim ……means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

Claim Administrator……means Blue Cross and Blue Shield of Illinois.

Claim Charge……means the amount which appears on a Claim as the Provider's or supplier's charge for goods or services furnished to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider or supplier. (See provisions of this Benefit Booklet regarding ``Claim Administrator's Separate Financial Arrangements with Providers.")

Claim Payment ……means the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. The term "Claim Payment" shall not include any payment for a benefit paid for through Physician Service Fees. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge, Maximum Allowance, Prescription Drug Program Eligible Charge and/or Dental Maximum Allowance, in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between Claim Administrator and the particular Provider. (See provisions regarding "Claim Administrator's Separate Financial Arrangements With Providers" in Exhibit 3.) The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

Clinical Appeal ……means an appeal related to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that do not meet the definition of an Urgent/Expedited Clinical Appeal.

COBRA ……means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 P.L. 99-272, as amended which regulate the conditions and manner under which an employer can offer continuation of group health insurance to employees and their family members whose coverage would otherwise terminate under the terms of this program.

Coinsurance ……means a Copayment that is a percentage of an eligible expense that you are required to pay towards a Covered Service.

Coordinated Home Care Program ……means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. A Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of your Physician, a Physician assistant who has been authorized by a Physician to prescribe those services, or an advance practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

Continuous Ambulatory Peritoneal Dialysis Treatment……means a continuous dialysis process using a patient's peritoneal membrane as a dialyzer.

Copayment ……means a specified dollar amount that a Covered Person is required to pay towards a Covered Service.

Coverage Date ……means the date on which benefits administered under the Health Care Plan begin.

Covered Service ……means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

Custodial Care Service ……means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a covered person's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

Dentist ……means a duly licensed dentist.

DHS-Certified Provider ……means a provider certified to provide ACT and CST by the Illinois Department of Human Services' Division of Mental Health and approved to provide ACT and CST by the Illinois Department of Healthcare and Family Services.

Diagnostic Mammograms ……means a mammogram obtained using Diagnostic Mammography.

Diagnostic Mammography ……means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

Diagnostic Service ……means tests performed to diagnose your condition because of your symptoms or to determine the progress of your illness or injury. Examples of these types of tests are x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, computerized tomography ("CT scans"), magnetic resonance imaging ("MRI") and positron emission tomography ("PET scans").

Dialysis Facility ……means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Domestic Partner.....means a person with whom you have entered into a Domestic Partnership.

Domestic Partnership.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of

your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

Early Acquired Disorder ……means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

Electroconvulsive Therapy ……means a medical procedure in which a brief application of an electric stimulus is used to produce a generalized seizure.

Eligible Person ……means an employee of ours who meets the eligibility requirements for the Health Care Plan, as described in the ELIGIBILITY section of this Benefit Booklet.

Emergency Medical Condition.....means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) serious impairment to bodily functions;

c) serious dysfunction of any bodily organ or part;

d) inadequately controlled pain; or

e) with respect to a pregnant woman who is having contractions:

1. inadequate time to complete a safe transfer to another hospital before delivery; or
2. a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Services ……means, with respect to an Enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered Inpatient and Outpatient Hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee ……means the person who has applied for benefits administered under the Health Care Plan and to whom the Claim Administrator has issued an identification card.

Enrollment Date ……means the later of: (a) the date we receive your completed application; or (b) your Coverage Date under the Health Care Plan.

Experimental/Investigational (also referred to as "Investigational")……means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as "Standard Medical Treatment" of the condition being treated or any of such items requiring federal or other governmental agency approval not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, medical treatment includes medical, mental health treatment, Substance Use Disorder Treatment, surgical, or dental treatment.

"Standard Medical Treatment" means the services or supplies that are in general use in the medical community in the United States, and;

a) have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

b) are appropriate for the Hospital or facility in which they were performed; and

c) the Physician or other professional Provider has had the appropriate training and experience to provide the treatment or procedure.

Family Coverage ……means benefits administered under the Health Care Plan for you and your eligible dependents under the Health Care Plan.

FIRST.IL Provider ……means a provider contracted with the Illinois Department of Human Services' Division of Mental Health to deliver coordinated specialty care for first episode psychosis treatment.

Habilitative Services……means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an Eligible Person keep, learn or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include Therapy for a child who isn't walking or talking at the expected age and includes Therapy to enhance the ability of a child to function with a Congenital, Genetic or

Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology and other services for an Eligible Person with disabilities in a variety of Inpatient and/or Outpatient settings, with benefits as described in this Benefit Booklet.

Hearing Aid……means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

Hearing Care Professional…… means a person who is a licensed Hearing Aid dispenser, licensed audiologist, or licensed physician operating with the scope of such license.

Hospice Care Program ……means a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program service is available in the home, or in Inpatient Hospital or Skilled Nursing Facility special hospice care unit.

Hospice Care Program Provider ……means an organization duly licensed to provide Hospice Care Program service.

Hospital ……means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

Individual Coverage ……means benefits administered under the Health Care Plan for yourself but not your spouse and/or dependents.

Infusion Therapy……means the administration through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

Inpatient ……means that you are a registered bed patient and are treated as such in a health care facility.

Life Threatening Disease or Condition ……means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Long Term Antibiotic Therapy……means the administration of oral intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

Long Term Care Services ……means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

Maintenance Care ……means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy ……means therapy administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur.

Marriage and Family Therapist ……means a duly licensed marriage and family therapist operating within the scope of such license.

Medical Care ……means the ordinary and usual professional services rendered by a Physician, Behavioral Health Practitioner, or other specified Provider during a professional visit, for the treatment of an illness or injury.

Medicare ……means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

Medicare Secondary Payer or MSP ……means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Mental Illness ……means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or any mental health condition that occurs during pregnancy or during the postpartum period, including but not limited to, postpartum depression.

"Seri1ous Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

Eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Naprapath …….means a duly licensed naprapath operating within the scope of such license.

Naprapathy Services …….means the performance of Naprapathy practice by a Naprapath which may legally be rendered by them.

Non-Clinical Appeal …….means an appeal of non-clinical issues, such as appeals pertaining to benefits and administrative procedures.

Occupational Therapy ……means a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Ongoing Course of Treatment ……see provision for "CONTINUITY OF CARE".

Optometrist ……means a duly licensed optometrist.

Outpatient ……means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program ……means a Hospital's planned therapeutic treatment program, which has been approved by your Participating IPA or Participating Medical Group, or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment, in which patients with Mental Illness spend days. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an inpatient unit, i.e. medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and if otherwise available, in person or by telephone to provide assistance and direction to the program as needed. Participants at this level of care do not require 24 hour supervision and are not considered a resident at the program. Requirements: Blue Cross and Blue Shield requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by your Participating IPA or Participating Medical Group as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Participating IPA ……means any duly organized Individual Practice Association of Physicians which has a contract or agreement with the Claim Administrator to provide professional and ancillary services to persons enrolled under this benefit program.

Participating Medical Group ……means any duly organized group of Physicians which has a contract or agreement with the Claim Administrator to provide professional and ancillary services to persons enrolled under this benefit program.

Pharmacy ……means any licensed establishment in which the profession of pharmacy is practiced.

Physical Therapy ……means the treatment by physical means by or under the supervision of a qualified physical therapist.

Physician ……means a physician duly licensed to practice medicine in all of its branches.

Physician Assistant ……means a duly licensed physician assistant performing under the direct supervision of a Physician.

Podiatrist ……means a duly licensed podiatrist.

Prescription Drug Provider ……means any Pharmacy which regularly dispenses drugs.

Primary Care Physician (PCP) ……means a Provider who is a member or employee of or who is affiliated with or engaged by a Participating IPA or Participating Medical Group and who is a) a Physician who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics, psychiatry or family practice, or b) a Chiropractor, and who you have selected to be primarily responsible for assessing, treating or coordinating your health care needs.

Private Duty Nursing Service ……means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service is shift nursing of eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Provider ……means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services and/or the Independent Physician Association(s) that facilitate(s) provision of Covered Services to Covered Persons.

Provider's Charge ……means a) in the case of your Primary Care Physician or another Physician who is affiliated with your Participating IPA/Participating Medical Group, the amount that such Physician would have charged for a good or service had you not been enrolled under this benefit program or b) in the case of a Provider or supplier which is not affiliated with your Participating IPA/Participating Medical Group, such Provider's or supplier's Claim Charge for Covered Services, unless otherwise agreed to by the Plan and the Provider or supplier.

Psychologist ……means:

a) a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois ``Psychologist Registration Act" (111 Ill. Rev. Stat. §5301 et seq., as amended or substituted); or

b) in a state where statutory licensure exists, a Clinical Psychologist who holds a valid credential for such practice; or

c) if practicing in a state where statutory licensure does not exist, a psychologist who specializes in the evaluation and treatment of Mental Illness and Substance Use Disorder and who meets the following qualifications:

    1. has a doctoral degree from a regionally accredited University, College or Professional School and has two years of supervised experience in health services of which at least one year is postdoctoral and one year in an organized health services program; or

2. is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College and has not less than six years-experience as a psychologist with at least two years of supervised experience in health services.

Radiation Therapy……means the use of ionizing radiation in the treatment of a medical illness or condition.

Renal Dialysis Treatment ……means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

Rescission …… means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

Residential Treatment Center …… means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and on-site nursing care and supervision for at least one shift a day with on call availability for other shifts for patients with Mental Illness and/or Substance Use Disorders. Blue Cross and Blue Shield of Illinois requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Illinois as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Respite Care Services ……means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services for you.

Routine Patient Costs ……means the cost for all items and services consistent with the benefits provided under the Health Care Plan, that is typically covered for an Eligible Person who is not enrolled in a clinical trial.

Routine Patient Costs do not include:

a) The Investigational item, device or service, itself;

b) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

c) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Skilled Nursing Facility ……means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service ……means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist Physician ……means a Provider with a contractual relationship or affiliation with the Participating IPA/Participating Medical Group who does not meet the definition of a Primary Care Physician, Woman's Principal Health Care Provider, or Behavioral Health Practitioner.

Speech Therapy ……means treatment for the correction of a speech impairment, including pervasive developmental disorders.

Standing Referral ……means a written referral from your Primary Care Physician or Woman's Principal Health Care Provider for an Ongoing Course of Treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman's Principal Health Care Provider, the consulting Physician or Provider and the Plan.

Substance Use Disorder ……means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Substance Use Disorder Treatment ……means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals (other than a Behavioral Health Practitioner), court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Use Disorder Treatment Facility ……means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Surgery ……means the performance of any medically recognized, non-Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Plan.

Telehealth/Telemedicine Services.....means a health services delivered by a health professional licensed, certified or otherwise entitled to practice in Illinois and acting within the scope of the health professional's license, certification, or entitlement to a patient in a different physical location than the health professional using telecommunications or information technology.

Tick-Borne Disease……means a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

(i) a severe infection with borrelia burgdorferi;

(ii) a late stage, persistent, or chronic infection or complications related to such an infection;

(iii) an infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention; and

(iv) with the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

Totally Disabled ……means, with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or, with respect to an Enrollee other than the Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

Urgent/Expedited Clinical Appeal ……means an appeal of a clinically urgent nature that relates to health care services, including, but not limited to, procedures or treatments ordered by a health care provider that, if a decision is denied, may significantly increase the risk to your health.

Vitamin D Testing ……means vitamin D blood testing that measures the level of vitamin D in a person's blood.

Woman's Principal Health Care Provider (WPHCP) ……means a Physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

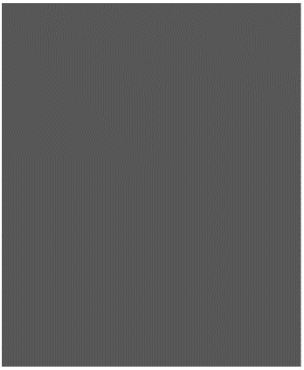
RIDER TO THE BENEFIT BOOKLET FOR DISABLED OR RETIRED PUBLIC EMPLOYEES

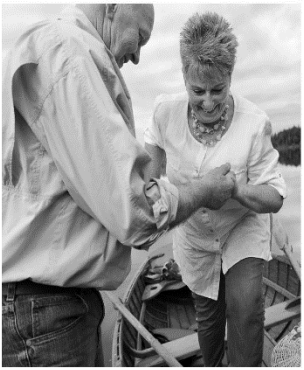
The benefit booklet to which this Rider is attached and becomes a part, is hereby amended as follows:

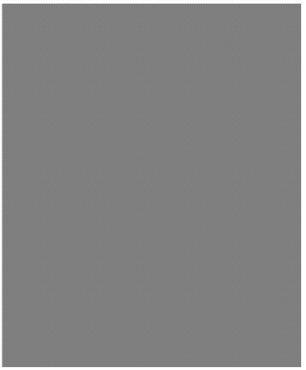
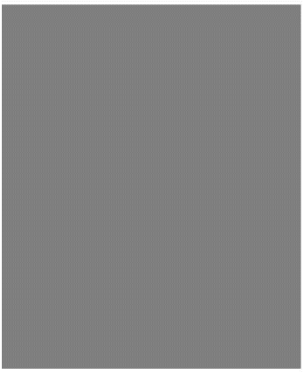
If you are a public employee and are eligible for continued coverage for accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued health coverage under this Health Care Plan, if you meet the following conditions:

1. You and your eligible dependents, must have been covered under this Health Care Plan on the day immediately preceding the effective date of eligibility for continued health coverage.
2. Once properly established, continued health coverage under this Health Care Plan may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform the Claim Administrator of the loss of eligibility.
3. The election by you or your surviving spouse, to obtain a conversion plan as described in the conversion provisions of this Health Care Plan shall terminate any right to continue health coverage according to Sections 367g, 367h and 367j of the Insurance Code. No reinstatement of continued health coverage shall be permitted after such conversion has been effected or if the continued health coverage provided by this Rider has been terminated for any reason.
4. If you or your surviving spouse is continuing coverage under this Health Care Plan and becomes eligible for Medicare, the benefits under this Health Care Plan shall be reduced in accordance with the benefit provisions for Medicare Eligibles stated in this benefit booklet.
5. If a timely and valid election of continued health coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Employer by you.

Except as amended by this Rider, all terms and conditions of the benefit booklet to which the Rider is attached will remain in full force and effect.



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Effective Date: January 1, 2024

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.